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PROCEEDINGS: SECOND USER'S WORKSHOP ON COMBAT STRESS
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(ARMY) FORT SAM HOUSTON TX HEALTH C.

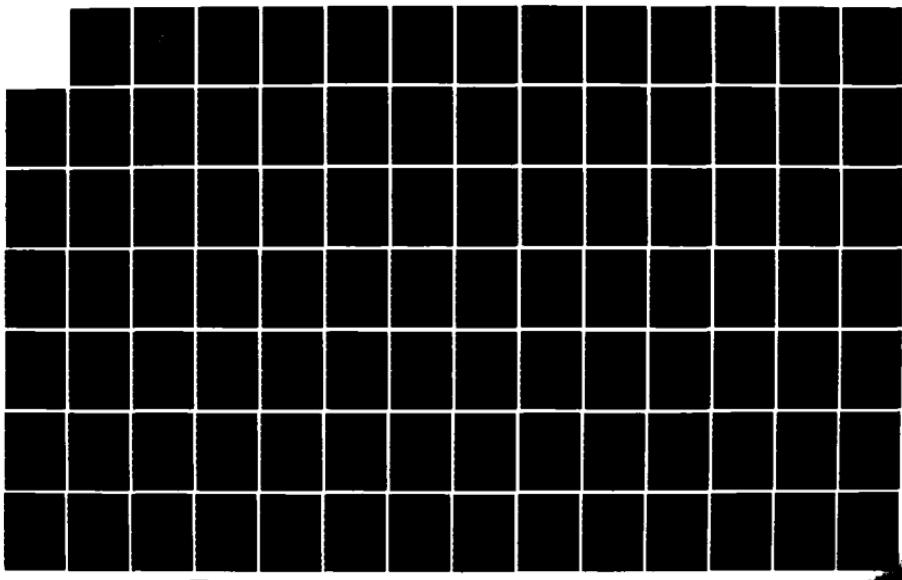
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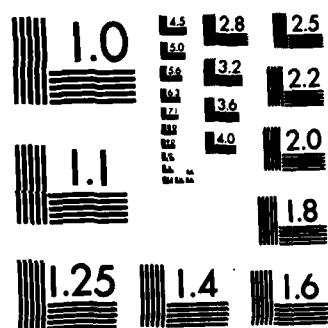
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PROCEEDINGS

SECOND

USERS' WORKSHOP

ON COMBAT STRESS

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Academy of Health Sciences
Fort Sam Houston, Texas

29 - 30 April 1982



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20. ABSTRACT (Continue on reverse side if necessary and identify by block number) The Proceedings document the workshop presentations and group reports. Combat stress casualties were analyzed for their historical significance. Recommendations to correct deficiencies in combat psychiatry and mental health services were discussed. The factors influencing combat behavior were examined as well as the functions of those dealing with combat stress casualties.		

Proceedings: Second Users' Workshop on Combat Stress
Academy of Health Sciences, Fort Sam Houston, Texas
29-30 April, 1982

PREFACE

The purpose of the Second Users' Workshop on Combat Stress was to present a forum to exchange ideas, share information on resources, and identify points of contact among individuals with an interest in combat stress. This proceedings documents the efforts of the participants. As more and more workers concerned with combat stress exchange ideas, better programs and training packages will evolve.

A. David Mangelsdorff, Ph.D.

MAJ T. Paul Furukawa, Ph.D.

Editors

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DEPARTMENT OF THE ARMY
ACADEMY OF HEALTH SCIENCES, UNITED STATES ARMY
FORT SAM HOUSTON, TEXAS 78234

REPLY TO
ATTENTION OF:

HSHA-CHC

18 March 1982

SUBJECT: Second Users' Workshop on Combat Stress

1. The Second Users' Workshop on Combat Stress is scheduled for 28-30 April 1982 at the Directorate of Combat Developments and Health Care Studies, Building 2000, Academy of Health Sciences, Fort Sam Houston, Texas 78234. This Workshop will focus upon the role of the line and the role of the mental health staff in training troops, leaders, and AMEDD/mental health personnel in preventing, recognizing, and dealing with the anticipated high numbers of combat stress reactions in future war scenarios. The Workshop will offer the opportunity to learn current trends and proposed doctrine concerning combat stress, to exchange ideas about training needs and programs, and to critique the proposed combat mental health portion of the Mission Area Analysis (which will strongly influence Army and AMEDD priorities in the future).
2. A critical element in this Workshop is the active participation by combat arms and combat support leaders and trainers, in concert with their mental health consultants, from units which will be among the earliest to mobilize for war. This combination is intended to provide a suitable and credible evaluation of proposed doctrinal materials.
3. Since participant spaces are limited, selection for attendance will be based upon the following priorities:
 - a. Unit is willing to have both line officers with command or training responsibilities and mental health officers attend.
 - b. Unit is willing to locally fund one or more attendees.
 - c. Unit is likely to be mobilized early in any future large scale conflict.
 - d. Unit is willing to give Workshop attendees the opportunity to incorporate relevant Workshop materials into present training programs.

HSHA-CHC

18 March 1982

SUBJECT: Second Users' Workshop on Combat Stress

e. Participants are willing to exchange some of their own training materials, if applicable.

4. Nominees for Workshop attendance should make telephonic contact (followed by a letter) as soon as possible, providing information concerning the above priorities.

5. Workshop Points of Contact at the Academy of Health Sciences, US Army are MAJ T. Paul Furukawa and Dr. A. David Mangelsdorff, Health Care Studies Division, AUTOVON 471-4541/3331/3116/6514.



HELMER W. THOMPSON
Colonel, MSC
Director, Combat Developments and
Health Care Studies

1 Incl w/1 incl
1. Fact Sheet

FACT SHEET

HSHA-CHC
Dr. Mangelsdorff and
MAJ Furukawa/221-3116/3331
AUTOVON 471-6514/4541

SUBJECT: Second Users' Workshop on Combat Stress

PURPOSE: To provide information on the background, scope, and agenda of, and participants in, the Second Users' Workshop on Combat Stress, 28-30 April 1982.

FACTS:

1. Background.

a. In the Central Battle scenario, combat stress casualties are projected as the largest single category of casualties as well as the largest potential source of trained and available replacements.

b. The Directorate of Combat Developments and Health Care Studies serves as the AMEDD focal point for collection, dissemination, and consultation about concepts, combat developments, and casualty estimation models. As part of the Army-wide Mission Area Analysis (MAA) effort, the Directorate is preparing materials for staffing regarding the "combat stress casualties and mental health services" portion of the AMEDD input into the MAA. In order to identify the full ramifications of these developments, there is a need to bring together some of the expertise in the field of combat stress, the potential AMEDD and line users and trainers, and subject-matter researchers.

2. Scope.

a. The intent of the Users' Workshop is to provide a forum for information exchange and discussion.

b. Academy faculty will present information on current developments in threat, psychiatric support systems, and proposed tasks/functions in dealing with combat stress reactions, and combat mental health Mission Area Analysis.

c. Participants from the combat units are asked to bring and describe whatever training programs, handouts, packets, or written ideas they may have for training soldiers, leaders, medical, and mental health personnel.

d. The outcome of the Users' Workshop will be that participating division-level mental health staff and line personnel will be prepared to identify their unique training needs, commit themselves to developing and

conducting their own training programs, evaluate their own programs, and share the results of the evaluation with the Academy and other participants at a later date.

3. Proposed Agenda: see Incl 1.

4. Points of Contact are Dr. A. David Mangelsdorff, Ph.D. and MAJ T. Paul Furukawa, Health Care Studies Division, AUTOVON 471-4541/3331/3116/6514. If both are unavailable, contact CPT Linda Sauer at same telephone numbers.

SECOND USERS' WORKSHOP ON COMBAT STRESS
Academy of Health Sciences
Fort Sam Houston, TX 78234
29-30 April 1982

AGENDA

Thursday, 29 Apr 82

0745 hrs Congregate at Bldg. 2000. Walk to Workshop Room.

0800	Welcome	COL H.W. Thompson Director, Combat Developments & Health Care Studies, AHS
0810	Introductions and Purpose	MAJ T.P. Furukawa, DCDHCS, AHS
0930	Combat Stress Casualties in Perspective	COL W.F. Schultheis, Brooke Army Medical Center
0915	The Threat	MAJ W.H. Thornton, DCDHCS, AHS
0945	BREAK	
1000	DIV 86 and Mission Area Analysis (MAA)	COL J. Stokes, AHS
1115	Battlefield Organizational Effectiveness	CPT B. LeRay, OE Center & School Fort Ord, CA
1135	Nutrition and Combat Stress	CPT M. O'Brien, OEC, AHS
1200	LUNCH (bus to dining facility and return)	
1330	Tasks and Functions of CSR Helpers	Dr. A.D. Mangelsdorff, DCDHCS, AHS
1400	Leadership & Triage in Combat Units	CSM W.D. Stock, 75th INF BN (Ranger), Fort Lewis, WA

1445 hrs	BREAK	
1500	Commentary on Managing Stress Casualties	Dr. Pincus Harris, WRAIR
1545	Small Groups: Training for CSR Casualties	Dr. A.D. Mangelsdorff and Group facilitators
1630	ADJOURN (socializing & dinner)	

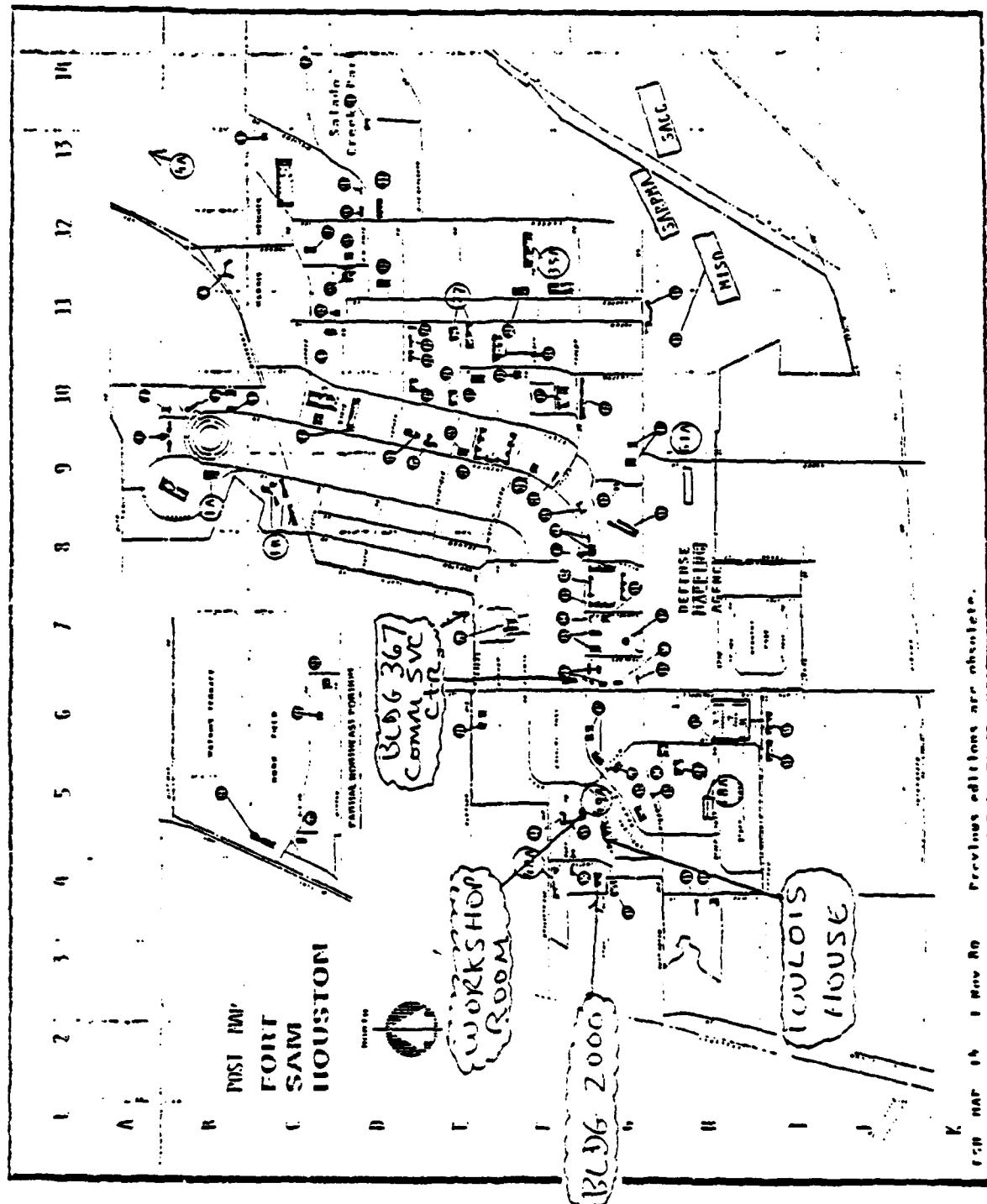
Friday, 30 Apr 82

0800 hrs	Small Groups (continued)	Group facilitators
0900	Plenary: Sharing of Goals	Dr. A.D. Mangelsdorff
0930	Training Exercise	COL J. Stokes
1200	WRAP UP	Dr. A.D. Mangelsdorff

Welcome to the Second Users' Workshop on Combat Stress

1. Attached map (over) may be useful.
 - a. Bldg 367 - YOU ARE HERE.
 - b. Foulois House - Where you will stay.
 - c. Bldg 2000 - Where we will congregate at 0745 hrs, Thursday.
 - d. Workshop Room - Where the Workshop will be held.
2. Breakfast (Thursday, Friday): Snack bar/cafeteria open at 0700 hrs, located on ground floor, Bldg 2000.
3. Lunch (Thursday): All to eat at mess hall. Transportation will be provided.
4. Dinner (Thursday): To be decided. Can be a group activity if you have no other plans. Transportation can be arranged.
5. Messages.
 - a. Routine messages routed through Health Care Studies Division (AUTOVON 471-4541, 3331, 3116, 6514).
 - b. Emergency messages at Workshop Room (AUTOVON 471-3274, 5600).

MAJ T. PAUL FURUKAWA (494-0544)
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Proceedings: Second Users' Workshop on Combat Stress
Academy of Health Sciences, Fort Sam Houston, Texas
29-30 April 1982

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Proceedings: Second Users' Workshop on Combat Stress
Academy of Health Sciences, Fort Sam Houston, Texas
29-30 April 1982

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NOT USED

PRESENTATIONS

NOT USED

COMBAT STRESS CASUALTIES IN PERSPECTIVE

COL William F. Schultheis, MC
Brooke Army Medical Center
Fort Sam Houston, Texas

ASSUMPTIONS:

The FIRST BATTLE of the next high intensity war will utilize a CENTRAL BATTLE SCENARIO, and will be fought on an integrated battlefield.

50 out of every 100 battle casualties will be psychiatric within the FIRST 48 hours.

Pulses of battle will exceed 10-12 per day.

WWII: 4-5 pulses per day.

REVIEW OF TREATMENT PRINCIPLES:

- +BREVITY -- Treatment should be brief.
- +IMMEDIACY -- Treatment should be instituted as soon as possible.
- +CENTRALITY -- Treatment should be centralized.
- +EXPECTANCY -- Convey positive expectation that soldier will return to duty.
- +PROXIMITY -- Provide treatment as far forward as possible.
- +SIMPLICITY -- Keep treatment methods simple.

BRIEF HISTORICAL REVIEW

1. KUMANO WAR (603 B.C.):

- * "Evil Gods Spewed Out Poison -- People and Things all Became Ill."
- * Malady disappeared after troops rested and morale restored.

2. CIVIL WAR:

- * Nostalgia: "Mild Insanity Caused by Disappointment and Longing for Home."
- * Defective Character, Poor Moral Turpitude.
- * 5,200 Cases Hospitalized.
- * Poor Medical Evacuation Channels.
- * 1863 - Incidence Rate 0 -- By Directive.
- * Psychosomatic Hospitalizations Soared.

3. RUSSO-JAPANESE WAR (1904-1906):

- * Russian Psychiatrists Assigned Forward.
- * Forward Treatment Centers Established.
- * First Accurate Description of Traumatic War Neurosis.
- * Initially Effective -- Later Broke Down.
- * Proximity.

4. WW I:

- * General Gorgas Dispatched Committee to France (1917).
- * Formation of 110 Bed Psychiatric Hospitals Suggested.
- * Base Hospital #117 Established.
- * 3,300 N/P Patients Admitted.
 - 50% Returned to Combat.
 - 41% Other Duties.
- * Proximity Re-Emerged as Primary Treatment Principle.
- * Clinical Picture: Tremors, Paralysis, Mutism, Ganser Syndrome.

5. WW II:

- * No Effective Treatment-Evacuation Policy Existed Until 1943.
- * No Designated P/N Consultant TSGO.
- * Feb 20, 1943 -- Kasserine Pass -- Green, Well-Equipped American Troops Were Tested by Africa Corps.
- * Situation Rectified.
- * P/N Center Located on Normandy Beachhead.
- * Clinical Picture: Depression, Apathy, Psychosomatic.
- * "Tremblers of WW I Became Gastric Neuroses of WW II."

6. KOREA:

- * Psychiatric Casualties Initially Low -- Troops Retreating.
- * Pusan Perimeter -- Casualty Rate Increased -- Static Defense.
- * All Divisions (Pusan) Had Division Psychiatrist.
- * Too Many Evacuated to Japan.
- * NP Centers Established in Korea.
- * 80% Returned to Duty.

7. VIET NAM:

- * Atypical When Compared With All Previous Wars.
- * Low PN Casualty Rate (5%).
 - * Limited Tour of Duty.
 - * R & R.
 - * Superior Aero-Medical Evacuation Policy.
 - * Intense, Brief, Sporadic Engagement With Enemy.
 - * Full Compliment of Divisional Mental Health Officers.
- * What is "Viet Nam Veterans Syndrome"?
 - * Delayed Stress Reaction?
 - * Depressive Variant?

8. ISRAELI CONFLICT (1973):

- * Many Similarities to Envisioned Central Battle Scenario of Western Europe.
 - * Brief -- 3-4 Days.
 - * Mobile.
 - * Fluid.
 - * Intense -- Initially Fought 24 Hours a Day.
 - * Heavy Casualties.
 - * Integrated -- Air, Armor, Artillery Closely Coordinated.
 - * High N/P Casualty Rate.
 - * Re-Emergence of Treatment Principles.
 - * Treatment:
 - * Rest.
 - * Encouragement.
 - * Ventilation (Abreaction).

NOT USED

THREAT

MAJ William H. Thornton, MSC
Academy of Health Sciences
Fort Sam Houston, Texas

THREAT

At the Battlefield Stress Meeting held last year, Major Ray Keller presented the concept that an assault by Soviet and Warsaw Pact Armies into Western Europe following established Soviet doctrine would lead inexorably to the isolation of front line combat units. This isolation, under perhaps the most difficult conditions ever faced by American soldiers would have a direct bearing on the production of combat exhaustion casualties. I wholeheartedly agree with this estimate - and wish to take it one step further.

Soviet attack doctrine shown here in its basic concept places an unrelenting pressure on defending front line forces. Fresh Soviet/Warsaw Pact forces are constantly pushed forward against defenders subjected to the rigors of the technologically advanced, fully integrated battlefield. Combat units will be isolated with command, control and communications functions severely degraded. There will be neither rest nor respite from the terrors of battle.

Behind this ongoing front-line battle, in the division and corps area, safety and security will not be assured. Note the majority of our medical units are found in this area. Enemy forces operating in up to divisional strength may be engaged in intensive combat with US and Allied forces. This is the Soviet Rear Area Threat.

The Soviets are convinced of the value of offensive rear area operations. This stems not only from their own successful use of such operations against the Germans and Japanese during the last war, but also from their painful experience with German diversionary teams behind Soviet lines. The threat against our rear areas can be identified as is shown on this chart: Viewgraph #4, Soviet Rear Area Threat. Time constraints preclude an indepth review of each of these items. I would like to make a few comments on some of these however.

Conservative estimates place the number of Agents currently residing in West Germany alone at 9,000 - 12,000. These are personnel equipped with clandestine communications equipment, armed, and with specific targets for destruction assigned. Bridges, supply depots, airfields, assassines, etc., these constitute the missions of such personnel. Terrorist groups receive arms, training and financial support from Soviet and Warsaw Pact governments. How they would react in a major conflict is unknown; but they are a force to be reckoned with under all conditions.

The Soviets currently have seven airborne divisions, with the airlift capability to deploy two divisions simultaneously. Corps rear areas offer the most lucrative targets to airborne assault.

Lastly, the NBC warfare threat potential is well recognized. Denial of critical areas to include supply depots, main transportation routes, and bridges can severely hamper Combat Service Support activities in the European theater. Soviet operations in the US/NATO rear will not in themselves be of sufficient scale to bring about a Soviet victory. They are designed to create fear, panic, confusion and loss of confidence in the civilian and military population as to our ability to defeat the threat; as well as disrupting operations required to support combat forces. By creating such disruption and reducing the effectiveness of our forward defenses, the Soviets hold, the advancing main forces are assured of a rapid and successful advance.

How does all of this impact on us, the medical planners, trainers and deliverers?

Constant combat in the front lines by isolated units, which may, due to circumstances be unable to evacuate casualties, necessitates a higher degree of sensitivity on the part of both tactical commanders and medical personnel to prevention, recognition and early treatment of combat exhaustion casualties aimed at earliest possible return to duty.

The Soviet capability to conduct extensive rear area operations on such a scale and with such a range of options as previously shown, can only serve to heighten the overall burden on all the soldiers in the combat zones. Certainly, more neuropsychiatric disorders can be expected in the rear areas than have occurred in past conflicts.

Given the nature of modern warfare with its increased intensity and lethality, we must be prepared to handle a larger patient population suffering from combat exhaustion.

SOVIET ATTACK DOCTRINE

MASSING OF FORCES	(Multi-Divisional Attacks)
CONTINUOUS ASSAULT	(Echelonnement) (Day-Night)
INTENSIVE COMBAT	(Massed Artillery) (NBC) (Full Spectrum Radio-electric Combat) (Advanced Technology: Directed Energy Weapons)

SOVIET REAR AREA THREAT

Soviet Controlled Agent Activity
Terrorist Groups
Soviet/Warsaw Pact Sympathizers
Diversionary Operations/Sabotage Teams
Reconnaissance Units
Airborne Assault Operations
Airpower, Artillery and Missile Strikes
Radioelectric Combat
Nuclear, Biological and Chemical Warfare
Tank Battle Incursions into the Rear Areas

MISSION AREA ANALYSIS:
RECOMMENDATIONS TO CORRECT DEFICIENCIES
IN COMBAT PSYCHIATRY & MENTAL HEALTH SERVICES

COL James W. Stokes, MC
Academy of Health Sciences, US Army
Fort Sam Houston, TX

Efforts are underway to reorganize the Army to meet new threats and to make best use of new equipment. Field Medical Support and Combat Mental Health Services are a part of this effort.

"Division 86" (actually a series of TOE revisions for the heavy, light and airborne/air assault divisions), "Corps 86" and "Army 86" are continuously-evolving projects which should begin to be implemented by 1986-87. These changes are required by a belated appreciation of Threat capabilities, and by delivery of new weapons systems whose development was driven by high-technology without a full appreciation of how they should be integrated into the entire force structure. To get ahead of the problem next time, TRADOC is instituting a program to identify needs, deficiencies and potential breakthroughs well in advance. In the long term, this is called "Air Land Battle 2000;" in the mid term, "Mission Area Analysis (MAA)."

MAA is an Army-wide program which involves all the branch schools' Combat Development staffs, plus the Research and Development community. Using the Scenario Oriented Recurring Evaluation System (SCORES) wargames as data, it pits our 1987 Force Structure (i.e., the Div 86 promises) against the 1990 NBC Threat in Central Europe and the Mid-East. The objective is to identify all deficiencies, analyze them in detail, prioritize them, and recommend corrective actions. The prioritized list will then be used to determine where training, personnel, materiel and research resources get allocated.

The MAA list will be updated periodically, but if some proposed change is not on that list, it cannot expect to be funded. This is a "zero-sum game" being played with limited budgets. The "best" solutions will be those which involve cheap improvements in doctrine and procedure or inexpensive improvements in training. Only if those do not suffice can requests for additional personnel or materiel be justified. Personnel additions, in particular, are likely to come out of a Branch's own hide; no other branches think they have too many slots, and both the Army as a whole and specific units such as the division have congressional or DA ceilings on personnel strengths.

Within the MAA, the Medical Department has only a small place. There are twelve major Army Mission Areas, such as "Close Combat," "Fire Support," and "Intelligence." All of "Combat Service Support" is just one area, coordinated by the Army Logistics Center (Ft Lee). The "CSSMAA" contains nine sub-areas, of which "Medical Support" is only one. The Directorate of Combat Developments and Health Care Studies at the Academy of Health Sciences is responsible for that sub-area.

Where do "Combat Mental Health Services" stand in this? Virtually forgotten, due to the passage of time since WWII and Korea, our "success" during Vietnam in reducing traditional combat exhaustion, perhaps some guilt by association for "failing" to solve drug and behavior problems, and our preoccupation with clinic, hospital and garrison problems through the 1970's. When the Academy's Combat Developments Directorate defined the major medical sub-tasks for MAA, they used as their reference FM 8-10 "Health Services in the Theater of Operations;" FM 8-10 does not mention the Mental Health Services at all and acknowledges psychiatric augmentation teams (the OM Team) only in a table.

The twelve major medical subtasks which have been defined for MAA are: Medical Treatment; Patient Evacuation and Regulation; Preventive Medicine Services; Clinical Lab Services; Blood Banking Services; Optometric/Optical Services; Dental Services; Medical Supply and Maintenance; Hospital Food Services; Medical Intelligence; Medical Command/Control and Communication. Although Mental Health Services (even more than some of those listed) exist as distinct entities within the garrison community and division medical TOE, involve several unique professional and specialist disciplines, and serve a variety of non-patient care functions, they are by omission subsumed in the vast subarea of Medical Treatment for the MAA. To change this as Doctrine will require a long and laborious process. However, Combat Developments Directorate is willing to let an Ad Hoc Combat Psychiatry and Mental Health Services Working Group proceed with the MAA process as if it were a separate area, the results to be submitted with the Medical Treatment deficiencies.

The groundwork for the MAA has been well-laid by a 1981 concept paper entitled "Theater of Operations Psychiatry Support System (TOPPS)." This paper grew out of a historical review by Gregory, Brooks and Lawson which documented the baseline 1:3 ratio of battle fatigue to WIA and projected that rate onto modern high-tech. conventional scenarios (1). Schultheis, Furukawa, Mangelsdorff, OTSG consultants, et al then wrote the TOPPS paper to sound the alarm about the Army's doctrinal unpreparedness, stress the need to prevent excessive evacuation of combat stress casualties, and recommend changes in organization to put mental health expertise at more forward echelons in the Divisions and Corps 86's.

TOPPS limited its concern to current deficiencies for conventional war, and explicitly did not address problems which might be generated by CBR use (or by women in the combat zone, drug abuse, etc.). The concept paper is still being staffed in the Academy, although steps have already been initiated to implement its training implications for the Academy curriculum.

The Combat Psychiatry and Mental Health Services Mission Area Analysis ad hoc interdisciplinary working group has picked up where TOPPS left off - addressing as MAA requires, the added threats of the 1990 integrated (NBC) battlefield. We have broadly categorized the major tasks of the Combat Mental Health Services into three functions: 1) prevention through education, command consultation and early intervention, 2) differential diagnosis and triage, 3) management of casualties. The latter subdivides into: a) treatment of salvageable cases, primarily with reassurance, rest, replenishment of physiologic reserves, and restoration of self-confidence by supportive psychotherapy and appropriate duties, b) control of disruptive behavior and evacuation of unres- torable cases. The caseloads for combat psychiatry and mental health services

will certainly increase in absolute number and diagnostic complexity on the NBC Battlefield, and perhaps even in relative proportion to WIA. A number of clinical entities must be considered, as follows:

1. "Normal" non-incapacitating battle stress reactions.

2. Conventional battle stress casualties, which can be sub-divided clinically into: a) transient battle reactions (disaster shock syndromes); b) battle fatigue from sustained operations (with a strong component of fatigue); c) survivor burn out (the "old sergeant syndrome" of WWII, which may appear much sooner in high intensity war). Whether these should be given different labels in the field or be lumped under one non-descriptive label like "battle fatigue" (which implies only that it is transitory and gets better with rest) must still be resolved at a tri-service level.

3. CBR Conversion Reactions (or "Integrated Battle Fatigue") are defined here separately as "hysterical" symptoms which mimic true chemical, biological, nuclear, and laser injuries (in practice, these too should probably be labeled "battle fatigue"). During WWI, "Gas mania" was estimated to outnumber true gas exposure 2:1 in relatively inexperienced troops, and could lead to permanent "gas neurosis" and disability unless early diagnosis, reassurance and immediate return to duty was practiced.

4. Acute Organic Mental Disorders may be more common than in past wars due to concussion from massive artillery bombardments, low doses of CW agents, incapacitant agents, inappropriate use of atropine antidote, other substance abuse (intoxication and withdrawal), and heat stroke brought on by CW protective measures.

5. Psychologically distressed wounded, ill and injured are a potentially large group. These include conventional injuries with excessive disability, pain or battle fatigue symptoms when faced with return to combat. Others may have had real chemical or radiation exposure and be justifiably concerned about their life expectancy, especially if expected to return to duty.

6. The endemic neuropsychiatric disorders such as the schizophrenias and personality disorders.

It is clear that on the NBC battlefield, differential diagnosis of functional from physiological disorders will be even more difficult than in the past, and may have to be done in mass casualty settings. Many more physical and psychological casualties may occur in the Corps areas and COMMZ than ever before. Yet successful return to duty of salvageable functional cases (or of nondisabling or treatable organic ones) requires that they be recognized close to their units and receive reassurance, rest and restorative support rather than further evacuation. What do Division and Corps 86 provide to accomplish this, and what does TOPPS plus CPMHSMAA recommend be added?

At the most basic level, much must be done to educate the troops and small unit leaders during basic training, Officers Basic and Advanced Courses, the staff schools and OJT. What is taught must be carefully chosen, as a little knowledge can be worse than none, especially about a disorder which is as subject to suggestion as battle fatigue.

Unit aidmen will still be the first level of medical intervention. The more junior of these may be "91 A's" who have had a shorter Academy course than the 91 B's; in any case, postgraduate and field training from the Division Mental Health Section will be essential to teach aidmen what they need to know about prevention, diagnosis, triage, and basic management. Research might provide a safe, non-abusable sleep aid (perhaps L-tryptophan) or behavioral stress reduction techniques which could enable the "medic" to restore more soldiers at his unit. A safe drug for quickly controlling psychological or toxic agitation could also be useful.

At the Maneuver Battalion Aid Station, Div 86 proposes to have both a physician and a physician assistant, with two treatment vehicles so they can move by alternate bounds, but with very limited holding capability. (Support units will still have one vehicle, one "doc.") Additional training is needed at the BAS, plus improved diagnostic criteria (and technology?) to identify the organic disorders and determine actual severity of CBR insults. In addition to a benign sleep aid and "super tranquilizer," the BAS could also use better drugs than Valium to reduce anxiety; these would allow many soldiers with battle fatigue to get rested and reintegrated in the battalion, brigade, DISCOM or COSCOM logistical trains instead of having to be kept under medical/mental health supervision.

At the Brigade level, Division 86 has streamlined The Brigade Clearing Station into the "Medical Company (Forward)" by pulling its 40-cot holding platoon back to the division rear. The Med Co (Fwd) will still have two 91G Behavioral Science Specialists, and the rank of these is to be increased to E6 and E5 in view of the importance of triage at this level. However, our MAA working group is arguing that this is not enough. The key problems in differential diagnosis will require the integration of medical and psychological examining skills and authority - for example, to distinguish the functional CBR conversion reactions from the true CBR injuries; the heroine overdose from nerve gas poisoning; the atropine psychosis from alcoholic DT's, etc. We are recommending that one of the four physicians in the Med Co (Fwd) in combat be a psychiatrist (60W) rather than a GMO or a second surgeon, internist or emergency physician. The 60W would, of course, also function as a general medical officer. The 91G's should also be recognized in the TOE as the Mental Health Section and the senior 91G as the Brigade Mental Health NCO; ideally, he should be an E7, to give him even greater clinical experience, plus the stature to get the attention and cooperation of the brigades' senior NCOs.

At the Division Medical Support Company (now with 160 cots), the Division Mental Health Section has its psychiatrist (60W), psychologist (68S), social worker (68R), and E4 and E5 91Gs. These would be stretched very thin by the several hundred to a thousand cases they might be resting and replenishing at one time in the mass casualty NBC scenario. We are recommending addition of a full-time Division Mental Health NCOIC (91G E8) whose administrative skills could help organize expedient helpers and coordinate DISCOM R&R resources (as well as enhance training in peacetime). Augmentation in wartime should include at least one more mental health officer (60W, 68R, or 68S), perhaps one or two 91F Psychiatry Specialist (to manage psychotic cases whose evacuations may well be delayed), and perhaps an Occupational Therapy Officer. But the real overload situations are more than a division can cope with logistically, and it will either need substantial reinforcement from Corps or have to send its overflow back to Corps facilities.

The Medical Clearing Company (Separate) in the Corps area may provide this back-up. Corps 86 proposes it is to have a psychiatrist and eight 91Gs in addition to its three general medical officers and three 80 cot holding platoons. Holding platoons can be detached to augment divisions or corps hospitals; alternatively, the entire company could form one big rest and replenishment center. This facility is a good start, but we are recommending it be augmented with a psychologist and social worker so that a mental health officer could accompany each detached platoon. Some Occupational Therapy and Physical Therapy officers and enlisted specialists would also be useful additions to the Med Clr Co (Sep).

Neuropsychiatric cases with poor chance for rapid recovery should be evacuated out of the theater by way of the Evacuation Hospitals, but evacuation may be deferred in favor of severely wounded patients. The EVAC has a psychiatrist, psychiatric nurse (66C) and two 91Fs (decreased from four in the previous TOE). We recommend three 91Fs (allowing two on shift around the clock), plus a senior 91G to assist with triage and treatment of walk-in battle fatigue cases.

The Combat Support Hospitals, MASHs, Field Hospitals, and Team OA dispensaries in the Corps are have no mental health personnel. At the least, a psychiatric nurse (66C) should be assigned to each CSH and MASH with primary duties as a med/surg nurse. The Field hospitals which provide area support for high risk Corps support units and may receive overflow from divisions would benefit from a psychiatrist and some 91Gs; a full NP/mental health service with 68S and 68R would be better. Training in combat stress management must also reach to the Corps support units.

The Big Question in these scenarios is the role of the OM Team (Psychiatric Service). This is a hefty organization on paper, with an O6 psychiatrist commander, an O4 psychologist and E7 91F in its HQ section; a 25-bed treatment team with psychiatrist, two psychiatric nurses and 11 91Fs; and three Mental Hygiene Consultation teams, each with a psychiatrist, two social workers, and six 91Gs. However, it seems to lack any doctrine for the extended, high-intensity battlefield. We recommend that the two OM teams which could be mobilized in Europe be fully designated and informed, the MOBDES 60W commanders be "double-hatted" as "Corps Psychiatrist" for the two corps, the psychologists be assigned as full-time deputy commanders, and detailed plans for the teams' use be prepared. The OM teams could also be augmented with Occupational Therapist and Physical Therapist officers and enlisted personnel to team up with the Med Clr Co (Sep) in the Corps area.

There are also one active duty and six reserve OM Teams "on paper" in CONUS. These should be mobilized and sent over to Europe (or elsewhere) much earlier in the Time Phased Force Deployment to reinforce the Corps and to improve area coverage in the COMMZ.

In the European scenario, it must be recognized that the distinction between "Combat Zone" and "Communications Zone" may be purely administrative. The COMMZ's Station Hospitals (200, 300, and 500 bed) have a psychiatrist and a 91G (probably sufficient for limited consultation to local dispensaries, triage and brief walk-in treatment). The 1000-bed General Hospitals have an NP service with a psychiatrist, neurologist, psychologist, social worker, and four 91Gs. These appear well-suited to back up the Station Hospitals in the area support role. However, their primary doctrinal mission is to receive evacuees from the combat zone, most of whom will be the severely disturbed cases who could not be sent directly to CONUS because wounded patients had priority. Several 91Fs (and ideally a 66C

psychiatric nurse) would improve the General Hospital's ability to provide in-patient care for these psychotic patients until after an OM Team's treatment section arrives to augment it.

Another unit which would be of more value earlier in the deployment than currently scheduled is the Convalescent Center, which includes a psychiatrist, social worker, psychologist, 91G, and three 91Fs. These also should be given some Occupational Therapists.

It is obvious that much needs to be done to improve our capacity to return Battle Stress Casualties, Acute Organic Mental Disorders, and Psychologically Distressed Wounded, Ill and Injured soldiers to duty to win the critical first battles of a high-tech war. Much can be done just by improving training (at all levels), by providing doctrine for existing entities like the OM Team, by augmenting TOE units with available TDA personnel in wartime, and by delivering back-up or reserve elements to the battlefield earlier in the deployment (when they are most needed). Some additional mental health personnel slots do appear necessary, and improved materiel (especially in diagnostic and pharmacologic areas) would also help a lot.

The first step for all of these corrective actions (training, doctrine, personnel, and materiel) must be to gain a high enough priority within the total Mission Area Analysis. If we can make clear the extent to which the AMEDD's Combat Psychiatry and Mental Health Services are essential to prevent an unacceptable "hemorrhage" of combat power and to return to their units a large number of casualties (which may exceed all other WIA combined!), our priority for corrective action will be assured.

REFERENCE:

Gregory, G.A., T.R. Lawson, and F.R. Brooks. Behavioral Science Support in the Theater of Operations: Casualty Generation Study. Behavioral Science Division, Directorate of Training, Academy of Health Sciences.

TASKS AND FUNCTIONS IN DEALING WITH COMBAT STRESS REACTIONS

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Health Care Studies Division
Academy of Health Sciences

The tasks and functions needed to be performed for recognizing and dealing with stress reactions can be broken down into four areas of responsibility: individual soldiers, leaders, AMEDD personnel, and mental health personnel. Each level of responsibility has similar types of decisions to make with regard to psychiatric casualties; however, the degree of intervention becomes more sophisticated with the decision to move a stress casualty away from the combat situation.

The term psychiatric casualty or transient battle reaction/battle fatigue refers to transient emotional reactions to the stresses of combat. The manifestations may be either psychological and/or physical; they represent a collection of ineffectiveness conditions with varying organic, psychological, social, cognitive, motivational, and political components (Rath, 1980). The symptoms may change in a matter of several hours to several days, depending upon the individual, the nature of the combat, and how the casualty is labeled. A soldier who becomes a psychiatric casualty is ineffective in his combat role for reasons other than wounds, organic disease or ineptitude.

Individual Soldier Responsibilities.

The individual soldier needs to know the other squad and unit members. Cohesive units are established through effective training and team building. Individual soldiers probably are the first to know which members of the unit are not functioning up to the demands of a tactical situation. Soldiers compare themselves with each other to assess what responses other individuals are making to the tactical situation. Group consensus will unofficially decide what are the "normal" reactions for the individual in the combat/tactical situation. A buddy care system will be the first level for recognizing individual stress reactions. A fellow squad member will probably be the first to detect apparent wounds, injuries, chemical, or radiation exposures.

Leaders' Responsibilities.

Unit leaders (squad leader, platoon sergeant, platoon leader) have the responsibility for establishing cohesive units through effective training and adequate leadership. Leaders must continually assess the members of the unit who are not functioning up to the demands of the tactical situation. Leaders need to determine the nature and amount of individual soldier's fatigue, stress, duration of exposure, disease, fear, chemical exposure, and/or radiation exposure. Unit cohesion, team building, buddy system techniques must be emphasized. Leaders must decide whether reactions are normal to the situation. Individuals must cope alone, or at least within the unit. Soldiers must be encouraged to carry out their duties (even though not necessarily symptom free).

For soldiers unable to cope, temporary rest breaks may help. Leaders must reassure their soldiers of what constitutes normal reactions to the situation. If a soldier's symptoms are disruptive and/or he cannot exercise his combat

skills or effectively perform his duties in a reasonable amount of time, the leader should call in the assistance of an aidman.

AMEDD Personnel Responsibilities.

The aidman must assess whether the soldier is disabled from: an apparent wound, injury, disease, chemical exposure, or stress reaction. The aidman must decide whether the reactions of the soldier are normal for an individual in the combat/tactical situation. The aidman must reassure the soldier of normal reactions to a situation. The aidman must assess the soldier from personal knowledge of the individual's past history and experience as to: how long in combat, previous stress reactions, previous medical treatments (what, how long ago, recovery time), and the tactical situation. The aidman must assess the soldier's capability of functioning from not functioning based upon: the aidman's knowledge of common symptoms, course, or phases of stress reactions. If possible the aidman should instill the expectation the soldier will return to duty. If rest is not helpful, the aidman must document the soldier's history and past military performance. Only if the tactical situation allows, should the aidman consider evacuating a soldier for further evaluation if necessary.

Physicians and PAs need to assess soldiers for apparent wounds or injuries before considering combat stress reactions. If reassurance and time do not resolve the soldier's behaviors, the soldier must be assessed for whether the behaviors will be disruptive. Soldiers capable of functioning in their combat role (though not necessarily symptom free), must be returned to their units. Only for soldiers not capable of functioning in their combat role and if the tactical situation allows, should AMEDD personnel consider evacuating soldiers for further rest and evaluation.

Mental Health Personnel Responsibilities.

Mental health personnel provide consultation during pre-deployment, pre-combat, and during combat to individual soldiers and commanders. Commanders and staff elements need to be aware of mental health concerns. Mental health personnel must be actively involved in education, prevention, and training programs.

In combat settings, mental health personnel assist soldiers to cope. Mental health personnel must determine if brief psychotherapy is required, or if medication is necessary, or what interventions are needed. The senior 91G should supervise individual soldiers not capable of returning and functioning in their combat role but who could be used in combat support roles. Mental health personnel must continue to instill the expectation that soldiers will return to their units. Only if the soldier cannot be restored to adequate functioning should further evacuation be considered.

TASK GROUPS

NOT USED

EASTERN TASK GROUP
LTC Alfred M. Coke
HQ, Office of the Chief of Staff
Washington, DC

PROBLEM STATEMENT: How to implement stress management training throughout the entire Army?

FACTS BEARING UPON THE PROBLEM:

1. The Surgeon General has proponent for stress management within the Army. Specifically the Academy of Health Sciences is responsible for medical education and combat stress.
2. A large body of research data exists on the subject of stress.
3. No consolidated plan exists for stress management training within the formal military school systems.
4. No plan exists for introducing stress management concepts simultaneously throughout the Army.
5. State of the art training is required to meet current needs.
6. Stress management is integral to the concepts of management.

DISCUSSION:

1. The Surgeon General's primary interest in stress lies in the medical area. Combat stress as a psychological and physiological phenomenon must be studied if we are to maximize knowledge about stress and minimize its debilitating effects. The Combat Stress Working Group is studying the subject by doing an historical review, writing a paper on the subject, and finally preparing a handbook, the *Psychiatric Principles of Combat Stress*. This effort is necessary but does not help the leader or manager for the Army at large. Other research is done by the SGO for users upon request. This research is given to the client and also filed in report form in the SGO's Medical Library headquartered in the Pentagon. There is no general distribution to the field where the squad leaders, platoon leaders, and company commanders would be able to benefit from the findings if they were applicable to their situation. In other words there is no connecting link between the researcher and the general Army.

2. A recent review of research abstracts, articles and books within the Defense Technical Information Center, the Army Studies Library, the SGO's Library, and other computerized sources located over 2000 items. There is no shortage of uncollated research data.

3. Any stress management program must be a combination of education and training. Part of the training must occur within the formal school systems. Currently no formalized stress management training program exists that begins with the young officer or NCO and is progressive with their promotion through the advanced school systems. Stress management is being taught in some service schools such as the Transportation School at Fort Eustis by an Organizational

Effectiveness Consultant (LTC Michael D. Mierau). There are others who are teaching the subject based on their belief that it is appropriate, important, and necessary. These are individual not organizational efforts. The Organizational Effectiveness Center and School is investigating the subject of stress but their material does not appear to have a valid personal or organizational model by which their consultants or Army leaders can transcribe stress into management actions.

4. Stress concepts must be interjected into the Army from the top down in a forceful manner that permeates all levels. It must be consistent with the Army's Management Goal and be ingrained within the Human Dimensions and Leadership Objectives. It cannot be seen strictly as a medical problem but must be viewed as a responsibility of the chain of command. To leave it as a problem for the Division Psychiatrist instead of the Division Commander is to relegate it to an intangible dimension where one must see a specialist for treatment instead of corrective measures taken within the parameters of leadership.

5. Most stress training is a regurgitation of the basic concepts of teaching soldiers to eat right, stay in shape, and be positive in their thinking. Nothing is wrong with such an approach as long as it is recognized as basic personal skills. It does very little for the leader who is experiencing stress because of his overextended resources, limited time, workaholic boss, and nagging spouse. Advanced skills are required to teach the leader how to manage stress in himself and in others. The training MUST be conducted from the top down. Little is gained by teaching stress management to subordinates when the boss is the source of the occupational stress or is a poor role model for personal stress.

6. Additionally, most stress training is taught from a reactive mode. Once the stress has occurred it is too late. What needs to be recognized is that dysfunctional stress can be prevented. Concepts such as psychological hardiness obtained through seeking challenge in life, being committed to the task at hand, and being in control of one's situation are necessary for advanced skills training. These are usually not addressed because of the difficulty of training toward such "soft" objectives. It is a difficult but not impossible task. Difficult or not, the fact remains that business as usual will not suffice for stress management in today's complex Army.

7. The Soldier Support Center is doing a stress project funded by the Army Research Institute, and conducted by a contract organization. The ultimate goal will be to get the material institutionalized in some form of training program. Their report, Management of Stress in Army Operations, is in draft form at this time and little comment can be made concerning its content in this paper. Some projections can be offered. If the project addresses stress training as a progressive process from the individual soldier to his highest levels of leadership in both the peacetime and combat scenarios, the project will be of great value. If it is only combat focused it will be neglecting the role played by most military persons for the majority of their service. If it is a series of skill building training objectives for every level of Army management, it will be consistent with the current needs. If it is bottom loaded with lots of training for the soldier, less training up the chain of command, and briefings on the subject to the senior officers, then the project is less than complete. If the project is only medically focused without an integrated leadership-management orientation then it has revisited the basic tenets of stress management with little sustenance for teaching advanced skills.

8. Management experts study organizations by using a number of systems approaches. A simple technique to do this is to look at the system as a black box and to determine what is causing the system to get out of balance. This state of imbalance or violation of the Universal Law of Homeostasis is one definition of stress. To study stress one must look at it from a systematic approach within the framework of management principles and practices. Two Organizational Effectiveness Consultants (Coke & Mierau) are using a Corporate Fitness Formula in their consulting and training. They report it to be an appropriate vehicle to implement measures toward rebalancing the system.

9. The Comptroller of the Army has the responsibility for the development of the management goal. The Organizational Effectiveness Office of the Director of Management, OCSA is writing Army Regulation 5-1 which spells out the details. The DCSPER has the responsibility for developing the Leadership Goal for the Army. Historically there has been competition between the leadership and management factions. Unfortunately Army leaders often tend to see management not in its true sense as the integration of hard process skills with people relations, but rather as a function of "bean counters." The Management supporters see Leadership supporters as emotional persons who don't understand the broader picture of the issue. Stress training must be brought into the system by those with the responsibility for leading our soldiers, whether it is labeled leadership or management.

CONCLUSIONS: The Army has the technical information available to develop a systematic, managerial approach to stress training. It has the research capacity to fine tune the data. A formal system exists for training of commissioned and non-commissioned leaders. A staff agency exists at the Department of the Army level to integrate the concept into leadership and management documents. A consulting organization exists to integrate the material into the organizational effectiveness network. What is missing is the recognition of the magnitude of the stress problem.

NOT USED

WESTERN TASK GROUP
CPT Howard H. Anderson III
MEDDAC, Fort Riley, Kansas

1. The final activity of the Second Users' Workshop on Combat Stress resulted in breakdown of attendees into task groups. Whereby each group was to assess needs of members and a common theme amongst the group.

2. The "West Group" consisted of the following members:

LTC Thompson
MAJ Richardson
CPT Anderson
CPT Cragon
CPT Ekwurzel
CPT LeRoy
CPT Whyte

The group composition was made up of teachers, consultants, line personnel, and treaters. The heterogeneity of the group found various individual needs with the common theme being the need to deliver information on Combat Stress to Army personnel. Individuals in the group were at various stages of a delivery package.

3. The initial problem presented was the need to identify individuals and/or organizations who should receive information on Combat Stress. Simultaneously, resistance by the target population must be regarded in attempting to market a program on Combat Stress. Who should receive this valued information? A question answered via various needs assessment techniques.

4. The current level of education in Combat Stress can be assessed with questionnaires; interviews with commanders and others in the chain of command (and their dependents); discussions with S-3 personnel (training section) regarding training schedules, SOP's, etc.; and observation of field exercises.

5. In addition to level of knowledge of Combat Stress there was found a requirement where units appearing to indicate more immediate needs of intervention would be approached first in Combat Stress education. The literature describes warning indications for possible failure of individuals or organizations if they were to engage in combat including: problems in leadership, unit cohesion, and troop morale (among others). Frequency of unit personnel (and dependents) visits to CMHA, AWOL and ART's 15, etc.; unit incidences of spouse, child, and alcohol/drug abuse; all are found to be probable warning indicators. Additionally, interviews with personnel and their families and consultation with other professional agencies will help to determine priority of needs.

6. The audience to receive combat stress education and the amount of information to be disseminated was found to be a problematic area. Should commanders be the only recipients of information on combat stress? Should the chain of command include the lowest ranking supervisor, or should "Pvt Tentpec" be included, knowing malingerer already exists in non-combat situations?

7. The possible resistance by individuals and organizations in their being receptive to combat stress input must be overcome. The marketing should include uppermost post command channels. Newspaper advertising can be used to create the sense of a need for combat stress education. The behavioral science professionals and line personnel must make a gradual entry into the personnel system, using language of their audiences, and have proximity and visibility to the target populations who are to receive the product.

8. Specific Methodology in combat stress training was presented by the West Group members. Small group sessions at unit level would facilitate cohesion in addition to team building exercises and group problem solving. The Martial Arts, relaxation training, teaching coping skills, use of meditation, and other individualized specialties were found to be combat stress training tools. Desensitization in experiencing combat conditions for units and individuals could be accomplished via close proximity to Artillery or simulated sights and sounds.

9. The evaluation criteria for the impact of combat stress training were found to be numerous. Observations of EDRE and ARTEP exercises will indicate the effectiveness of the education. Pretest and posttest questionnaires, comparisons of trained groups and groups not trained in combat stress and changes in combat stress warning indicators (CMHA stats, etc.) are useful evaluation criteria. Individual feedback can be obtained via consultations with commanders, and rap sessions with the troops.

10. The West Group's final concern was that combat stress education be an ongoing practice and an integral part of training. The need for the combat stress educators to keep an information exchange ongoing between themselves is vital or otherwise combat stress programs will fade away as individuals move onward.

TEXAS TASK GROUP

MAJ Gary Greenfield
William Beaumont Army Medical Center
El Paso, Texas

I. GROUP TASK: During the course of the workshop the participants were divided into work groups according to the region in which they currently worked. The Texas Group consisted of all attendees currently stationed in Texas. The Group was assigned the task of generating a list of concerns/problems/issues related to combat stress and then to generate a list of possible solutions within a non-evaluative problem solving format.

II. PROBLEM 1: How to get cooperation from line commanders for conducting combat stress training.

A. DISCUSSION: Virtually all of the members of this group have experienced considerable problems in obtaining active interest and cooperation from line commanders. Most of the attendees reported that commanders in their area were either not interested and/or uninformed about combat stress or simply overwhelmed by the various mandatory training requirements (and thus had precious little time to devote to adding training experiences to the already full training schedule).

B. SOLUTIONS:

1. Participants should complete an after action report as one way of bringing the issue of combat stress to command level. This is particularly important for participants who came from line units.

2. The participants and other members of their clinical staff (when the participants are medical persons) should volunteer to conduct unit training. This would place the burden of manpower and planning away from the line unit and make it easier to have the program placed on the training schedule. Some of the attendees felt that 91G personnel should conduct the training at company and platoon level and officers at battalion level and above.

3. Some members felt that providing the military community as a whole with information on combat stress might raise the awareness of various commanders and make the topic more acceptable to command. One specific suggestion was to use the post newspaper as one means of presenting this information.

4. Another method to increase the acceptability of the topic and to increase the awareness of command and senior NCOs would be to provide training in combat stress at the various military schools such as the U.S. Army Sergeant Majors Academy, Branch Advanced Courses, Senior Service Schools, etc.

5. Another method that was recommended was to find a general officer to act as one's sponsor. This general officer could be used to demonstrate high level interest and for various public relations (political) campaigns.

6. Another suggestion was that individuals interested in conducting this type of training should regularly participate in unit field training. This would have several positive effects to include (1) increasing rapport between the unit and the trainer, and (2) provide the possibility of spontaneous training conducted on the spot as lulls in the training process occur.

7. One of the most popular solutions was to develop a comprehensive initial presentation that would demonstrate the impact that psychiatric battle casualties would have upon the units' performance. This presentation should include examples from military history and epidemiological data when available.

8. Another proposed solution was to locate a sympathetic friend in a key staff officer position and help that person present your "case" to command. The basic concept here was that such a person would be an integral member of the unit (and not an outsider such as an AMEDD Officer) and as such have direct access to the commander on a regular basis.

9. The last proposed solution was that the provision of mental health services should be decentralized and moved away from the mental health clinic. Mental health practitioners, then, would spend their work hours not in a clinic but at the unit. This would provide day-to-day contact between the unit and the mental health practitioner and increase rapport. It would also allow the practitioner to become an integral part of the unit. This internal base was felt to be more viable not only for the purpose of conducting combat stress training but also for the delivery of front line mental health services.

PROBLEM 2: What can we do to foster unit cohesion?

A. DISCUSSION: Virtually all group members felt that the best hope to prevent combat stress casualties was to establish high levels of unit cohesion. It was felt that this group process variable held the key for prevention.

B. SOLUTIONS:

1. The group felt that the concept of cohesion was becoming a familiar one at all levels of command. Familiarity with the proposed regimental system, the COHORT program, etc., was felt to be crucial as a way of demonstrating to command that (1) the mental health officer was aware of what was taking place in the "real" Army, and (2) as a way to demonstrate the acceptability of this concept at the highest levels.

2. The group felt that one of the key aspects of cohesion was the perception by the soldier that his/her family would be taken care of in times of combat. The suggestion was made that we should become involved in the development of contingency plans for family members and the establishment of various social networks for family support.

3. Another proposed solution was to encourage the unit to develop an active unit sponsorship program to establish an early identification with the unit.

4. Another proposed solution was that various combat service support personnel should be assigned directly to the unit they are supporting. This decentralization was felt to be one way of enhancing the combat service support personnel's identification with the unit.

5. Although related to solution 4, the group felt that the need to get the mental health personnel out of the clinic and in to the field with their units merited special comment. All participants felt that the practice of waiting in one's clinic for the "patients" to appear was inappropriate and non-productive within the military environment.

6. The suggestion was also made that various mental health personnel should seek out social contact with the unit leadership as one way of increasing rapport and mutual trust.

PROBLEM 3: How to design physical training programs with combat relevance to stress management.

A. DISCUSSION: The groups felt that the physical training programs should be redesigned to (1) insure relevance to actual combat, (2) relate to MOS, and (3) to assist in the prevention of combat stress.

B. SOLUTIONS: This section will be written by another group member and submitted separately.

PROBLEM 4: The diverse background of the group served to identify yet another problem. Our group consisted of psychologists, occupational therapists, organizational effectiveness staff officers, social work officers as well as line officers. This multidisciplined group composition argued for a working paper which would begin to articulate what the relationship among the various helpers should be. Each specialty had ideas about what they should be doing, but it became clear as group work progressed, that no one had conceptualized an interface of helpers. The table below presents a model, for consideration, of behavioral science interventions required during 3 phases of armed conflict.

A RELATIONSHIP BETWEEN HELPERS BY TASKS: A WORKING MODEL

	<u>BEFORE</u>	<u>DURING</u>	<u>AFTER</u>
TASKS	Primary Prevention: Triage		Unit level information processing
	Education	Tailgate support	Closure on past conflict
	Preparation	(BICEPS rules applied)	Unit reconstitution
	Coping skills		
	Stress management		
HELPERS	MHOs	MHOs	OESOs
	OESOs		
	OTs	(OESOs in observation role)	(MHOs, OTs assist in preparation for next conflict)

This model proposes that in the Before Phase of conflict there is a role for all behavioral scientists. The objective is to assist unit preparation for combat by innoculating unit personnel against stress and increasing individual coping skills. During actual combat, the OESOs are essentially in an observation role while the MHOs are involved in triage and the application of BICEPS. In the After Phase the OESO, working with unit leaders, has the main role. MHOs and OTs can offer support and assistance in the preparation for the next conflict. This phase, in essence, becomes the Before Phase of the next conflict.

CONTRIBUTIONS FROM PARTICIPANTS

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INFLUENCING COMBAT BEHAVIOR

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INTRODUCTION

Confidence is the cornerstone of success in battle: each soldier's belief in his own competence, his trust in that of other members of his unit, and their collective pride, cohesion and effectiveness. (US Army Field Manual 100-5, 1 July 1976.)

Defeat...is one of the unavoidable fortunes of war; when two armies clash one must lose. Unfortunately defeat carries with it more than lost terrain and long casualty lists; it sows the seed of distrust in the fertile soil of the private soldier's brain; it implants the idea that the enemy may be physically superior to him and mentally superior to his leaders. With every battle lost, these doubts and questionings increase until finally they are fixed in irrevocable certainty. It is easy to lead victorious troops to fresh victories, but only great leaders can carry a defeated force through to triumph. Let us hope, then, that when we are engulfed in the next war we shall be able to give our armies a taste of victory in the fight. (COL Lanham, The Infantry Journal, 1936).

Combat readiness in the 1970's consists of two elements: hard facts and state of mind. Hard facts refer to the tangibles of war: men, materiel, and technology. State of mind refers to the intangibles of war: confidence, morale, and leadership. This paper is about confidence: the individual soldier's belief in his ability to win in combat.

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CHAPTER I

INDIVIDUAL BEHAVIOR IN A THREATENING COMBAT SITUATION

Why does an individual soldier act the way he does in combat? The answer to this question can be found by examining the four principle elements of a threatening combat situation: the objective situation, the subjective demand, the response to the subjective demand, and the consequences of the response.¹ In combat, these four elements occur much closer together in time than they do in normal day-to-day activities. In some cases, they occur almost simultaneously. Each of these four elements is considered below.

The Objective Situation

The objective situation refers to the actual sensory input that the soldier receives from his external and internal environment. External stimuli such as artillery fire landing close to his position, an order to "dig in," or a request from another soldier for first aid come to the soldier's awareness from some external source. Internal stimuli such as the pain from a twisted ankle, fatigue, or a headache result from the soldier's personal physical condition.

The Subjective Demand

The subjective demand concerns the soldier's recognition and

interpretation of the objective situation and his evaluation of his ability to deal with it. How the soldier constructs the evidence of his senses depends on many factors and is always liable to error. In combat, the situation is always hostile and unstable, so mistakes in the interpretations of reality are especially easy to make.

The principle factors that lead to a mistaken interpretation of a combat situation are:

1. Lack of experience.² The particular situation may be so far removed from the soldier's past experiences that he cannot understand what is happening.
2. Preconceived ideas. Prior to his arrival in combat, the soldier may have convinced himself that combat should proceed in a certain way. When a situation occurs that is somewhat similar to his preconceived idea, he may organize the stimuli to support his preconceived idea and not see the situation the way it really is.
3. Lack of knowledge.³ The soldier may be confronted with enemy tactics and weapons with which he is not familiar.
4. Lack of motivation.⁴ The soldier may not want to know what is going on.
5. Failure to see an event in context.⁵ The soldier may not see the big picture. In other words, the meaning he attaches to an event may be inappropriate when seen from another point of view.
6. An inability to accurately evaluate the capability of his military unit. The soldier may drastically overrate or underestimate

the capabilities of his leaders, his buddies, or his equipment.

The meaning of a threatening combat situation, then, depends on the soldier's interpretation of the situation, not on the objective facts; it is how he interprets the situation that counts. Regardless of how the situation "really" is, it is what the soldier "thinks" is real that is important.

After recognizing and interpreting the situation, the soldier evaluates his ability to cope with it. Depending on his evaluation, he will feel threatened in varying degrees. Generally speaking, the more confident he feels about his coping ability, the less threatened he will feel; and the less confident he feels about his coping ability, the more threatened he will feel.

Some of the factors that influence the soldier's estimate of his coping ability are:

1. The degree of physical threat. If the soldier is being physically overwhelmed by the enemy, he will feel less able to cope and, therefore, more threatened.⁶

2. His ability to locate the source of the threat.⁷ If he cannot locate a sniper, for example, he cannot effectively eliminate him; thus, coping ability decreases and threat increases.

3. The presence of alternatives.⁸ If the soldier thinks that there are some actions that he can take to eliminate the source of threat, he will feel less threatened than he would if no alternatives were available.

4. His prior experience.⁹ The soldier's evaluation of his coping ability in combat involves judgment and discrimination based largely on prior experience. If he has dealt successfully with similar situations in the past, he will feel more able to cope and less threatened.

5. His confidence in his military unit.¹⁰ If the soldier knows that his leaders and his fellow soldiers are competent, the threat will be less because of his confidence in the group's coping ability.

6. His confidence in his weapon, his equipment, and his fire support.¹¹ For example, if the soldier's experience has taught him that it takes 15 minutes to get on-call artillery fire support, he will feel more threatened in a difficult situation that develops suddenly because he views his coping ability and his leader's coping ability as limited by the time required to get the fire support.

7. His assessment of the environmental restraints.¹² The soldier may know what to do to eliminate the threat, but he may be prevented from doing so by some environmental obstacle such as a large open area, a river, or a ravine. Environmental obstacles that prevent positive action increase threat because they limit coping ability.

8. His disposition to act.¹³ Soldiers possess this quality in varying degrees. The action oriented soldier, the "doer," has a generalized kind of confidence in his coping ability. He usually feels less threat than the "non-doer," the soldier who lacks this generalized

confidence.

The soldier's evaluation of his ability to cope, like his interpretation of the situation, is a subjective matter. What he "thinks" is true, is true for him. Thus, there are great individual differences in coping evaluation. A threat to one soldier may be a challenge to another. A normally non-threatening situation may occur when a soldier is emotionally overloaded, thus precipitating a crisis.¹⁴ The reverse is also true. When a soldier is rested and fresh, serious threatening situations may not seem as bad as they really are.

In summary, the subjective demand involves the soldier's interpretation of the situation and his evaluation of his ability to deal with it. However, both interpretation and evaluation are liable to error. The soldier will feel more threatened when he interprets a situation to be beyond his response capability and less threatened when he feels capable of coping with the situation. It must be emphasized that interpretation and evaluation do not mean accurate, realistic thinking. A soldier may interpret a situation as more or less serious than it actually is, or he may overestimate or underestimate his ability to cope with it.

The Response to the Subjective Demand

The soldier's response to a threatening combat situation has many aspects. The most prominent aspects are confidence, group support, intensity of the threat, and the soldier's ability to control his

emotions.

1. Confidence. The most important aspect concerns the soldier's confidence in his ability to deal with the threatening situation.¹⁵ A confident response is characterized by actions aimed at eliminating or avoiding the source of harm and at reducing the unfavorable effects of the confrontation.¹⁶ In an attack situation, for example, the confident soldier acts aggressively and tries to keep himself alive while doing so. In another context, such as reconnaissance patrolling, a confident response to enemy action is avoidance. In a defensive situation, a confident response involves the strengthening of resources against the threat by digging in and by improving the defensive position.

Inadequate responses to threatening situations are usually characterized by despair and depression.¹⁷ These responses occur when the soldier becomes convinced that there are no effective ways of coping with the situation.¹⁸ For example, during an attack the despairing soldier may simply lay on the ground and refuse to move; in the defense, he may refuse to dig a foxhole.

2. Group Support. Group support is another crucial aspect that influences the nature of the soldier's response. As a rule, any loss of support from his group in the face of a threatening situation increases threat by weakening the soldier's ability to take positive action against the danger.¹⁹ The soldier is not his only resource against danger. His ability to get things done depends on the adequate

functioning of the rest of his military unit. The action of competent leaders and effective fellow soldiers reduces threat because effective action increases the coping ability of the group. Inaction increases threat in a crisis not only because group capability is diminished, but because group integration is decreased.²⁰

3. Intensity of the Threat. Another key aspect that influences the nature of the soldier's response to a threatening combat situation is the intensity of the threat. Adaptive and realistic forms of responding are more likely to occur when the threatening situation is comparatively mild. Under severe threat, extreme responses become more pronounced.²¹ As threat increases so do primitive responses,²² rigid problem solving behaviors,²³ and inappropriate emotional reactions.²⁴

4. Emotional Control. Associated with the responses to a threatening combat situation are the emotions of anger, fear, and despair. These emotions are related to the soldier's evaluation of the threatening situation,²⁵ and they facilitate or hinder his response.²⁶ *Confidence and Fear is usually related to Anger is usually related to approach behavior, and lack of confidence and defensive behavior. Despair and apathy are usually related to immobility and resignation.*²⁷

All soldiers will experience anger, fear, and despair at one time or another while in combat. These emotions are normal and appropriate as long as they do not reach a point where they interfere with the application of skills requiring initiative, effort, and ability. To the extent that the soldier can control these emotions, his ability to deal with the situation is facilitated.²⁸ For example, if the soldier

is pinned down by artillery and machine gun fire while moving toward his objective, the emotion of despair will probably occur. This emotion is normal for this situation as long as it is of short duration. However, if the soldier allows despair to get out of control, the result will be inaction. Ideally, he should recognize despair for what it is, a normal reaction, and then control it by taking some positive actions to cope with the situation such as returning fire and requesting additional fire support.

The Consequences of the Response

The fourth element in a threatening combat situation concerns the consequences of the soldier's response. If his actions are effective in influencing the situation to his advantage, confidence will increase and despair will decrease. If his actions are ineffective, or if he does not act at all, confidence will decrease while despair increases. Once again, however, a cognitive factor comes into play. The soldier makes a judgment about the effectiveness of ineffectiveness of his actions. This judgment may be correct or incorrect. For example, enemy soldiers may be withdrawing from the objective, not because of friendly action, but because they are going to use chemical munitions.

Summary

A threatening combat situation involves four elements: the objective situation, the subjective demand, the response to the subjective demand, and the consequences of the response. The objective situation

is what is actually happening in the environment and inside the soldier. The subjective demand is what the soldier "thinks" is happening as a result of his interpretation of the objective situation and of his evaluation of his ability to cope with the situation as he understands it. The response to the subjective demand is the action that the soldier takes in response to what he perceives as the real situation. The consequences of the response are the effects the soldier thinks that his actions are having on the situation.

A combat situation, then, involves a complex interaction between the environment and the soldier. The soldier will feel more threatened if he "thinks" that the situation is beyond his response capability and less threatened when he "thinks" that he can overcome the threat.

The question at the beginning of this chapter asked why a soldier acts the way he does in combat. He acts the way he does because of his evaluation of the situation and of his ability to deal with it. If he feels confident, he will get angry and do something constructive to change the situation. If he is not sure of his ability, he will be afraid and will act defensively. If he believes that the situation is definitely beyond his response capability, he will be overcome by despair and will do little or nothing.

FOOTNOTES - CHAPTER I

¹This model was taken wholly from J. McGrath, ed., Social and Psychological Factors in Stress (New York: Holt, Rinehart, and Winston, 1970), pp. 15-21.

²R. Lazarus, Psychological Stress and the Coping Process (New York: McGraw-Hill, 1966), p. 160.

³Ibid.

⁴Ibid.

⁵McGrath, p. 24.

⁶H. Appley and R. Trumbull, Psychological Stress, as cited by R. Lazarus (New York: Appleton-Century-Crofts, 1967), p. 163.

⁷Lazarus, p. 174.

⁸Ibid., p. 160.

⁹McGrath, p. 78.

¹⁰S. Kissel, "Stress - Reducing Properties of Social Stimuli," Journal of Personality and Social Psychology, 1965, 2(3), p. 378.

¹¹Appley & Trumbull (as cited by Lazarus), pp. 163-164.

¹²Appley & Trumbull, Psychological Stress (New York: Appleton-Century-Crofts, 1967), p. 170.

¹³E. Haggard, "Psychological Causes and Results of Stress," in Human Factors in Underseas Warfare, Lindsley, D. et al. (Washington, DC: National Research Council, 1949), p. 458.

¹⁴McGrath, p. 18.

¹⁵R. Grinker and J. Spiegel, Men Under Stress (New York: McGraw-Hill, 1945), p. 122.

¹⁶Lazarus, p. 256-259.

¹⁷Ibid.

¹⁸ Lazarus, p. 263.

¹⁹ Ibid., pp. 101-102.

²⁰ R. Hamblin, "Group Interaction During Crisis," Human Relations, 1956, 11, p. 75.

²¹ Lazarus, p. 162.

²² Ibid., p. 163.

²³ E. Cowen, "The Influence of Varying Degrees of Psychological Stress on Problem Solving Rigidity," Journal of Abnormal and Social Psychology, 1952, 47, p. 518.

²⁴ Lazarus, p. 6.

²⁵ C. Fritz, "Disasters Compared in Six American Communities," Human Organization, 1957, 16, p. 6-7.

²⁶ Appley & Trumbull as cited by M. Arnold in "Stress and Emotion," p. 127.

²⁷ Lazarus, p. 263.

²⁸ McGrath, from article by D. Mechanic, "Some Problems in Developing a Social Psychology of Adaptation to Stress," p. 115.

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CHAPTER II

FOUR STAGES OF BEHAVIOR IN INTENSE COMBAT

In intense infantry combat situations like those experienced by soldiers at Normandy and Guadalcanal, incredible demands are made on the soldiers' physical and emotional resources. Food and water are usually scarce. Mud, rain, insects, lack of sleep, and a heavy pack are the soldiers' constant companions. During actual contact with the enemy, the soldier is often afraid and confused. When he is not in contact, the noises of war are a constant reminder of dangers yet to be faced. The interwoven effects of these stresses are cumulative, and they gather momentum.¹ Even though the soldier may be in top condition prior to combat, he still has a limit of physical and emotional endurance. It can be said almost with certainty that most infantrymen, if exposed to very intense combat long enough, will suffer from combat exhaustion regardless of their previous physical and emotional condition.² The principal reason that there were not more combat exhaustion cases at places like Normandy and Guadalcanal was because most soldiers were wounded, killed, or evacuated for other medical reasons before combat exhaustion had a chance to set in.

Combat exhaustion, then, is a fact of combat. It is going to occur in some cases regardless of the actions taken by the small unit infantry leader. Not all cases of combat exhaustion, however, are

inevitable. There are some measures that an infantry leader can take to stop or delay the onset of combat exhaustion. What are they?

Before this question can be answered, the infantry leader must understand that there is a generally uniform pattern of behavior in intense infantry combat³ and that this pattern is influenced by the casualty rate:⁴ the more casualties, the faster the onset of combat exhaustion; the fewer the casualties, the slower the onset. Although there are large individual differences, there are relatively specific behavioral characteristics associated with different stages of this pattern. The four stages are: the initial combat adaptation stage, the maximum effectiveness stage, the overreaction stage, and the emotional exhaustion stage.⁵

The Initial Combat Adaptation Stage

During the first few days of combat, the soldier's behavior is directed toward becoming "battle wise." He learns how to distinguish between enemy and friendly battle noises, how to use cover and concealment, and where to look for the enemy. Fear fluctuates wildly. However, as the first few days go by, fear usually comes under the soldier's control. In other words, combat effectiveness and control over fear increase rapidly.

The soldiers' behavioral reactions during this period consist of some or all of the following: pounding heart, increased urinary frequency and urgency, intense thirst, trembling, increased sweating,

tension of muscles,⁶ a fear of being left alone, and a fear of exposing himself.⁷ These common reactions are perfectly normal. The soldier usually gains control over them to the point that they do not interfere with his combat performance.

The Maximum Effectiveness Stage

During this stage, the soldier's actions are oriented primarily toward coping with those aspects of the environment that are related to his combat mission. Fear control, confident action, and efficiency reach their highest levels during this stage. The maximum effectiveness stage usually lasts from eight to thirty days in intense combat. At some time around the twenty-fifth day, the first signs of combat exhaustion begin to appear.

The Overreactive Stage

The most common behavioral manifestation of early combat exhaustion is an abnormal state of fatigue that cannot be relieved by a good night's sleep. Those fear reactions that occurred during the first few days of combat begin to reappear more frequently and are overcome with less success.

Instead of responding to those aspects of the combat environment which are related to the combat mission, the soldier begins to respond in a defensive way to whatever part of the environment that presents a threat to him. Instead of making confident, aggressive responses, his behavior becomes increasingly dominated by anxiety and by defensive responses.

Behavior in the overreactive stage is characterized by all of the behaviors described in the initial combat adaptation phase, except that the behaviors are stronger in intensity. The soldier exhibits a decline in confident actions and in "battle wiseness." He shows an increase in excessive defensive reactions, overcautiousness, irritability, restlessness, and difficulty in sleeping. He may begin to see himself as being in a situation beyond his control, and he is more likely to blame others for his present situation. If this sense of helplessness continues to dominate the soldier's thinking and the intensity of combat continues at a high level, the soldier will slip into the last of the four stages.

The Emotional Exhaustion Stage

The behaviors typical of this stage are characterized by despair and apathy. They include all of the behaviors pointed out previously plus the more severe ones that may require medical attention. Combat exhaustion may be indicated by any of the following personal behaviors:

1. Severe anxiety characterized by confusion, immature behavior or erratic behavior.⁸
2. Extreme, everpresent fatigue.⁹
3. Chronic insomnia.¹⁰
4. Extreme depression or stupor.¹¹
5. Radical personality changes.¹²
6. Severe memory disturbances.¹³
7. Uncontrollable shaking.¹⁴
8. Extreme difficulty in concentrating.¹⁵
9. Inability or refusal to eat.¹⁶

10. Frequent nightmares.¹⁷
11. Overpowering restlessness.¹⁸
12. Inability to move a part of the body or to use a sensory mode for no apparent reason.¹⁹
13. Abnormal preoccupation with the terror of recent combat experiences.²⁰
14. Severe vomiting, diarrhea, or abdominal cramps.²¹
15. Extreme suspiciousness.²²

The Influence of the Casualty Rate

The time factor in the onset of combat exhaustion is a function of the unit casualty rate. Generally speaking, the more casualties a unit suffers, the faster the soldier will move through the four stages. Also, a soldier from a unit with very high casualties over a short period of time usually breaks down in a very dramatic way.²³ There is usually some precipitating event, like a shell landing very close to his position, that releases a great display of highly emotional behavior. The soldier "blows up." On the surface it appears that the soldier "blew up" because of one event. This is not the case, however.²⁴ The soldier slipped through the first three stages very quickly and all it took was the precipitating event to throw him very abruptly into the fourth stage. Once the soldier calms down, he usually exhibits one or more of the behaviors characteristic of the emotional exhaustion phase.

A soldier in a unit that suffers moderate casualties usually slips through the four stages at a slower rate and slowly begins to

show despairing behavior without "blowing up."

Other Non-Adaptive Combat Behaviors

There are many observable, job related behaviors that can indicate to the small unit infantry leader that the stress of combat is becoming too much for one of his soldiers. These behaviors can occur at any time after entry into combat. When they occur, especially when they occur repeatedly after the first week or two of combat, they indicate that a soldier may be in the overreactive stage. The soldier may:²⁵

1. Run away, usually under fire.
2. Hide in his foxhole or bunker when he should be doing something else.
3. Refuse to fire at the enemy.
4. Refuse to evacuate the wounded or the dead.
5. Refuse to move from one position to another.
6. Follow simple orders only when threatened with a weapon.
7. Freeze in place.
8. Throw away his weapon or purposely get part of it dirty to make it inoperative.
9. Stop fighting when only slightly wounded.
10. Avoid his primary responsibility by carrying supplies or helping a wounded buddy when he should be fighting.
11. Fail to fire at a good target for fear of giving away his position.
12. Pretend to be sick.
13. Say he cannot make it.
14. Constantly malinger.
15. Imagine that he sees or hears things.
16. Tremble to such an extent that he cannot hold or fire his weapon, or fires wildly.

17. Breaks down and cries.
18. Shakes uncontrollably.
19. Talks excessively about danger and fears.
20. Deliberately acts in such a way as to reveal the friendly position.
21. Discards necessary equipment.
22. Fails to check, clean, or maintain weapons or equipment.
23. Lags behind or becomes separated from his unit.

Preventing Combat Exhaustion

How can an infantry small unit leader stop or delay the onset of combat exhaustion?

First of all, he must know his men and pay close attention to their behavior in combat. He must pay special attention to the men who have been in combat the longest because they are the ones most likely to exhibit stage three or stage four behavior.

Second, he must do everything possible to reduce casualties consistent with the mission. More combat casualties mean more combat exhaustion losses.

Last, he must establish some clearcut criteria for determining when to evacuate a soldier before the soldier becomes a victim of combat exhaustion. The following criteria are suggested. Evacuate:

1. When a soldier can no longer perform his job.²⁶
2. When a soldier is a clear danger to himself.²⁷
3. When a soldier's behavior adversely affects the safety and cohesion of his group.²⁸
4. When a soldier's response to a threatening combat situation is clearly not in proportion to the actual threat.²⁹

Prompt evacuation for possible and actual cases of combat exhaustion is a must. Front line first aid for these men should emphasize

reducing fear stimuli, rest, lightening the soldier's load, and empathy. Experienced medical personnel will determine the soldier's status, give him treatment, evacuate him, or return him to his unit.

Summary

Changes in the dominance of one type of behavior over another tend to occur in the form of a general pattern as exposure to intense combat continues. Depending on the intensity of combat, the casualty rate, and the time exposed to combat, effectiveness tends to increase in prominence for a period of time after the soldier becomes seasoned to the combat environment. It then tends to decrease in prominence, progressing eventually to the point of incapacitation.³⁰

Non-adaptive job related behaviors and the other behavioral manifestations of movement through the four stages are good indicators that the small unit leader can use to gauge the emotional status of his men. The infantry leader must develop his own criteria for the evacuation of soldiers prior to the onset of combat exhaustion.

The criteria must be tempered with judgment because of the great differences in individual reactions to combat. One soldier may show helplessness and despair on the first day of combat and require evacuation. Another soldier may exhibit effective behavior for up to a year or more in intense combat. These are exceptions, however. The vast majority of soldiers are neither exceptionally effective nor exceptionally ineffective soldiers. When exposed to intense or prolonged combat, almost all soldiers periodically show ineffective behavior.³¹ The leader must take these individual differences and limitations into consideration before he makes his decision to evacuate a soldier as a possible or an actual combat exhaustion casualty.

FOOTNOTES - CHAPTER II

¹R. Grinker and J. Spiegel, Men Under Stress (New York: McGraw-Hill, 1945), p. 32.

²R. Swank and W. Marchand, "Combat Neurosis: Development of Combat Exhaustion," Archives of Neurology and Psychiatry, 1946, 55, p. 243.

³This pattern was discovered by Swank and Marchand (above) and elaborated on by Kern (Note 7, below). The same behavioral pattern is described in the following references:

a. G. Beebe, and J. Appel, Variation in Psychological Tolerance to Ground Combat in World War II (Washington, DC: National Academy of Sciences - National Research Council, 1958).

b. R. Swank, "Combat Exhaustion: A Descriptive and Statistical Analysis of Causes, Symptoms and Signs," Journal of Nervous and Mental Disorders, 1949, 109, pp. 475-508.

c. R. Greenson, "The Psychology of Apathy," Psychoanalytic Quarterly, 1949, 18, pp. 290-303.

d. T. Lidz, "Psychiatric Casualties from Guadalcanal: A Study in Reaction to Extreme Stress," Psychiatry, 1946, 9, pp. 193-213.

e. L. Bartmeier, et al., "Combat Exhaustion," Journal of Nervous and Mental Disorders, 1946, 104, pp. 358-524.

f. A. Glass, "The Problems of Stress in the Combat Zone," Symposium on Stress, Army Medical Center Graduate School (Washington, DC: Walter Reed Army Medical Center, 1953).

g. R. Grinker and J. Spiegel, War Neuroses in North Africa, The Tunisian Campaign (January - May, 1943) (New York: Josiah Mary Foundation, 1943).

⁴Swank & Marchand, p. 244.

⁵Much of the material described under the four stages has been taken from Swank and Marchand, Note 2, above, and from Kern's elaboration. Note 7, below.

⁶J. Dollard, Fear in Battle (Washington, DC: Infantry Journal, 1944), p. 10.

⁷R. Kern, A Conceptual Model of Behavior Under Stress, with Implications for Combat Training (Alexandria, VA: Human Resources Research Office, 1966), p. 7.

⁸S. Weinberg, "The Combat Neuroses," American Journal of Sociology, 1946, 51, p. 465.

⁹Grinker & Spiegel, p. 210.

¹⁰Ibid.

¹¹W. Hubert, "Acute Nervous Illness in Warfare," Lancet, 1944, 240, p. 306.

¹²Grinker & Spiegel, p. 210.

¹³Ibid.

¹⁴E. Skinner, "War Neuroses," Clinical Journal, 1942, 71, p. 105.

¹⁵Grinker & Spiegel, p. 210.

¹⁶Ibid.

¹⁷Ibid.

¹⁸Ibid.

¹⁹Weinberg, p. 465.

²⁰Grinker & Spiegel, p. 210.

²¹Ibid., p. 108.

²²Ibid., p. 210.

²³Swank, Analysis, p. 481.

²⁴Lizz, p. 200.

²⁵Examples 1 through 18 are from R. Egbert, et al., Fighter 1: A Study of Effective and Ineffective Combat Performers (Alexandria, VA: Human Resources Research Office, 1958), p. 15. Examples 19 through 23 are from R. Weisiogel, J. Flanagan, and S. Billingsley, The Job of the Combat Infantryman (Technical Memorandum T-250) (Johns Hopkins University: Operations Research Office, 1954).

²⁶ Grinker & Spiegel, p. 83.

²⁷ Weinberg, p. 474.

²⁸ Ibid.

²⁹ Grinker & Spiegel, p. 83.

³⁰ Kern, p. 11.

³¹ Ibid.

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CHAPTER III

CONFIDENCE AND DESPAIR

In Chapters I and II, the mental states of confidence and despair are mentioned frequently. Confidence is characteristic of the maximum effective stage of combat behavior and is the result of an optimistic estimate by the soldier of his ability to cope with a threatening situation. Despair, on the other hand, is characteristic of the emotional exhaustion phase and is the result of a pessimistic estimate of his coping ability.

Combat behavior can be thought of as a result of these two factors: confidence and despair.¹ The confidence factor grows whenever the soldier controls or eliminates a threatening situation by his own actions. When the same or similar situation occurs again, he anticipates that he will be able to cope with it successfully because of his prior experience with the same or similar situation. The despair factor develops in a similar manner. Despair develops when a soldier fails to cope with a threatening situation. When the same or similar situation arises again, he anticipates the impact of the harmful consequences of the threat. This leads to defensive behavior or inaction.

Confidence and despair can be visualized as having two basic components:²

1. A general component, with strength based on all of the soldier's previous experiences in threatening situations, both in and out

of the service. This component is extremely difficult to change because it is part of the soldier's basic character.³

2. A situational component, which varies in strength for different threatening situations. The strength of this component for a given situation depends on the soldier's past experiences in identical or highly similar specific situations.⁴ This component is relatively easy to change through experience and training.

The combat soldier's performance in a threatening situation, then, is the result of the general confidence and despair components and the situational confidence and despair components. The general components of both confidence and despair, are usually beyond the small unit leader's influence so a detailed discussion of them is not included in this paper. The situational components are, however, within easy reach of the infantry leader because situational confidence and despair are the result of the soldier's formal training experiences during duty hours and of his informal experiences with his group and his leader after duty hours. The situational confidence and despair factors are influenced for better or worse by the total of these formal and informal experiences. With this in mind, what yardstick can a small unit infantry leader use to evaluate the impact of these formal and informal experiences?

The answer to this question is the central idea in this paper: the small unit infantry leader can raise combat efficiency to its highest level if he insures that the total of his men's experiences tends to increase situational confidence and reduce situational despair.

The leader must realize that the goal of 100 percent confident responses and no despairing responses to a threatening situation is an unrealistic goal. Soldiers just don't work that way. The goal should be to strive for a high level of confident behavior over a relatively long period while simultaneously reducing despairing behavior to its lowest possible level. Despairing behaviors cannot be completely eliminated or indefinitely delayed in the face of intense combat. They can, however, be reduced to a tolerable level in initial combat and postponed to some extent in later combat by adequate training.

Formal Training

Almost all studies of combat performance have shown that the effective combat soldier has confidence in his ability to function in a combat situation, has confidence in his group's capabilities, and has confidence in his leader. He is the soldier who knows what to do, wants to do it, and can do it in the face of emotional arousal. The leader's job is to develop soldiers like this during formal combat training. The challenge facing the combat trainer is to teach skills and confidence, not just skills alone. He can do this if he designs and conducts the training with the following two guidelines in mind: prepare the training experience and then prepare the soldier for the training experience.

1. Preparing the experience. The training experience and the total training situation should be designed to simultaneously teach a skill, increase situational confidence, and decrease situational

despair.⁵ Most skill training, especially tactical training, teaches the soldier to recognize particular situations and to respond to them with specific actions. For example, in a training situation the soldier crosses the line of departure, receives fire from the objective, receives arm and hand signals from his squad leader (the situation), returns fire, and advances toward the objective as part of his squad (the response). As he advances toward the objective, he evaluates the effectiveness of his actions by seeing if the enemy is withdrawing from the objective (feedback). All training situations have these three stages in common.⁶

a. The situation. These are the events that occur in the training situation which are expected to initiate certain responses by the soldier.

b. The response. These are the behaviors that are considered essential to combat performance.

c. Feedback. This is the sensory input that the soldier uses to evaluate the adequacy or inadequacy of his responses.

The key to preparing training experiences is to develop confidence and to decrease despair during all three stages. The situation (condition) must be arranged so that the soldier, especially the inexperienced soldier, feels that the response desired is within his response capability. The response (task) must be clearly understood by the soldier as well as being within his response capability. Once again, this is very important for inexperienced soldiers. Finally,

the feedback (standard) must tell the soldier whether his response is adequate or inadequate. If inadequate, the soldier must repeat the response in the same situation until his behavior becomes adequate and his confidence in his ability is firmly established.

The feedback element is critical. If the soldier does not learn the task to the required standard, the trainer has developed despair instead of confidence; he has created a loser instead of a winner.

The three stages of training (situation, response, and feedback) are intimately related to performance oriented training⁷ (conditions, task, and standard). For example, during "squad in the defense" training, a squad may be occupying a well fortified bunker while live recoilless weapon rounds are exploding all around the bunker (situation-conditions). To stop the fires, the squad leader must call for artillery fires to eliminate the recoilless weapon (response-task). The squad leader's call for fire and subsequent adjustments must cause artillery fire to land within 50 meters of the recoilless weapon (feedback-standard). The squad leader must continue to adjust the fire until the recoilless weapon is neutralized. If he cannot succeed immediately, he must continue trying until he can accomplish the task. When he can do it regularly, his situational confidence is increased, his men's situational confidence is increased, and his leader's situational confidence is increased. A great deal of care must be exercised with slow learners; however, slow or fast, the learners must continue on until they learn the task.

In summary, the infantry trainer must teach skills, increase confidence, and decrease despair by arranging training experiences for his men that resemble as closely as possible the situation that they will encounter in combat and by insuring that his men can respond to these situations to the required standard of adequacy. A good infantry trainer uses his imagination when designing training experiences, understands that every soldier does not learn at the same rate of speed, and is absolutely insistent that all soldiers who have the physical, mental, and emotional ability actually perform the required task to the required standard.

2. Preparing the soldier for the experience. The soldier's approach to a training situation, like his approach to a combat situation, is either primarily confident or primarily despairing. However, in order to learn those parts of the situation that are important to later combat performance, the soldier's confidence factor must be dominant during the entire training period.⁸ When a soldier's confidence is dominant, he looks for those factors in the environment that will help him get the job done. When despair is dominant, his orientation will be toward signs of physical or emotional harm. Consequently, the soldier may learn a great deal about what might go wrong, but nothing about how to cope constructively with the situation. Measures must be taken prior to training to insure that the soldier's approach to combat training is predominantly confident. Particularly important in this respect is the area of safety precautions.

Safety precautions are a necessary part of tactical and weapons training, but the emphasis on safety devices and precautions heightens the development of despair. The person responsible for safety during tactical live fire training and weapons training must recognize this problem and deal with it. Safety overkill will usually result in the development of despair.

The whole idea is to get the soldier in the right frame of mind prior to the training. If he feels confident, he will pay attention to the right things, learn faster, and feel better about what he learned. In any case, regardless of the soldier's frame of mind, the soldier must repeat all training until he is confident in his ability to repeat it in a similar situation.

Informal Experiences

The soldier's informal experiences are those experiences that a soldier has with his immediate group or with one or more of the group's members during other than formal training hours. Consider how the following experiences will influence the individual soldier's confidence: he gets in trouble with the police and no one will help him, his leader gets drunk on Sunday night with full knowledge that an important mission is coming up early Monday morning, his entire group comes to visit him at the hospital when he is sick, he finds out that half of his group smokes marijuana regularly after duty hours. All of these experiences, and the thousands of experiences like them, can be judged in terms of how they contribute to the confidence and despair

of each member of the group. The leader's task is to insure that the soldier's informal experiences increase confidence and decrease despair.

Summary

Confidence and despair have a general and a situational component. The general component is outside of the infantry leader's control. The situational component, however, can be influenced by the leader.

Formal training leads to the maximum development of confidence when conducted in accordance with the performance oriented training method. The infantry trainer must give equal consideration to preparing the training experience for the men and to preparing the men for the training experience.

Informal experiences influence confidence and despair just as much as formal training, and they are just as important.

The confidence - despair model described in this chapter is a simple and effective yardstick that the infantry leader can use to evaluate training, to evaluate the quality of his soldier's informal experiences, and to evaluate how his personal actions are influencing his men.

FOOTNOTES - CHAPTER III

¹The confidence-despair model was developed by A. Kern in A Conceptual Model of Behavior Under Stress, With Implications for Combat Training (Alexandria, VA: Human Resources Research Office, 1966). The model was also developed by the author, working independently, in 1975.

²Ibid., p. 19.

³Ibid.

⁴Ibid.

⁵Ibid., p. 38.

⁶Ibid., pp. 41-42.

⁷Department of the Army, How to Prepare and Conduct Military Training (Field Manual 21-6) (Washington, DC: Department of the Army 1975), pp. 4-7.

⁸Kern, pp. 38-39.

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CHAPTER IV

INCREASING CONFIDENCE AND DECREASING DESPAIR

There are many actions that the infantry leader can take during precombat training and during actual combat to increase the soldier's situational confidence and to decrease his situational despair.

The actions discussed in this chapter are listed under three headings: key combat skills, morale, and leadership. Each of these three areas are subdivided into precombat and during-combat actions. This division has been made only to simplify discussion. It must be emphasized that all of these actions are closely related; the initiation of one action has effects that influence the other actions. Also, many of the precombat actions are applicable during combat, and many of the combat actions are applicable prior to combat.

The actions listed below are the most relevant and important for increasing situational confidence and decreasing situational despair.

Key Combat Skills

1. Increase the soldier's ability to place a high volume of effective fire on the enemy. When fire superiority is established, confident, aggressive actions follows.

a. Precombat actions.

(1) Conduct frequent live fire exercises that stress volume, accuracy, and control of fire. The desire to aggressively

use his weapon must be instilled in every soldier. Emphasis must be placed on firing when ordered, regulating fire volume according to the threat, and ceasing fire when ordered. The soldier must be taught that overconservation of ammunition and waiting for a visible target is self-defeating.

(2) Conduct live fire training with the fire support means that will be available in combat but are not organic to the unit. Maximum emphasis must be placed on calling for, adjusting, and leaning into artillery, gunship, naval gunfire, and tactical air supporting fires. The soldier must have hands-on training with tanks, antitank weapons, and air defense weapons. If safety and ammunition constraints limit live fire training prior to combat, the chances are good that the soldier will not have enough confidence in himself to fire his weapon effectively. If the soldier is not confident, he may not fire his weapon at all.

(3) Conduct hands-on training with enemy weapons. This training should include demonstrations of the effects of these weapons. The primary emphasis, however, must be placed on practicing counter-measures, not on the effectiveness of the enemy weapon. Enemy weapons lose their mystery and unknown qualities when a soldier knows what they can do, and more importantly, how he can cope with them.

(4) Conduct frequent weapons proficiency and maintenance inspections. The soldier must be absolutely convinced that his weapon will function properly and that he can use it effectively under all

environmental and tactical conditions, day or night. An arms room full of clean weapons is great; a company of weapons experts with dusty, operational weapons is better.

b. During combat actions.

(1) Identify those men who do not fire their weapons. Once identified, the leader must devote the time necessary to insure that these soldiers fire their weapons when required. A simple and effective technique is to take the nonfiring soldier to a place where he has a clear sight of an enemy target. This does not have to be a live target. It may be a place where the enemy is only presumed to be located. If necessary, the leader must handle the nonfiring soldier like a recruit on the rifle range, making certain that he continues to fire for an extended period of time.¹ Once the initial resistance is overcome and confidence instilled, the soldier will find it much easier to fire his weapon at his next opportunity.

(2) Transfer those men who fire their weapons only when supervised. They are best transferred to a crew-served weapon. There, the crew will keep them going.² After assignment to the gun crew, the soldier must be trained on the crew weapon as soon as possible. On battlefields of the past, the soldier who would not or could not fire his weapon was carried through combat by his unit. On the modern battlefield, where every weapon is significant, the nonfiring soldier is a danger to his entire unit.

(3) Conduct onsite training of subordinates on the correct procedures to be used to call for and to adjust supporting fires.

This training is especially important when precombat training was inadequate. Emphasis must be placed on actual use of fire support means, not on dry runs.

(4) Conduct onsite small arms fire control training. Emphasis must be placed on the accurate and controlled application of fire power. Controlled fire power wins battles; unused fire power loses them. Once again, this is especially important for the unit whose precombat training was inadequate.

2. Increase the level of the soldier's tactical know-how. When a soldier knows what to do and he knows that his buddies know what to do, confident action follows.

a. Precombat actions.

(1) Apply the fundamentals of infantry combat such as fire control, camouflage, and the preparation of field fortifications in a wide variety of threat producing situations, terrain, and climatic conditions. Emphasis must be placed on convincing the soldier that he can personally cope with many difficult situations while still working together with others to accomplish a common task. "Nice to know" training cannot be afforded. Training time and training resources are too valuable to waste. Tactical training must stress fundamentals.

(2) Emphasize movement during tactical training and especially during live fire training. Movement and effective fire are closely related. A soldier who is not afraid to aggressively use his weapon is always looking for a good place from which to fire it.³ Conversely, the soldier who has a good place to fire from usually

fires more effectively and in a greater volume. The soldier must be taught to move and shoot. He must never be permitted to remain in one place on the ground for an extended period of time. He must move when it is required, and that will usually be very often during an infantry assault. The leader must understand that the longer a soldier stays on the ground, the more likely he is to remain on the ground. Aggressive movement by one soldier increases the confidence level of all of the soldiers that see the movement. Good movement habits must be developed during precombat training.

(3) During training, include the things that go wrong in combat: attacks get bogged down, men get wounded, and fire support does not show up on time. When these events occur in combat, confidence will dip temporarily regardless of prior training. On the other hand, if the soldier does not have any idea at all what he should do because he has not had any similar experiences during training, confidence will drop drastically. It is not possible to prepare the soldier for all possible contingencies; however, he must be prepared for the most probable ones.

b. During combat actions.

(1) Demand that the soldier apply and practice the basic fundamentals of infantry combat. He must be trained when on line, while in reserve, or when in a rest area. Tactical training must be a continuous process aimed at increasing confidence.

(2) Conduct detailed rehearsals until each soldier understands his individual duties. Successful rehearsals build confidence through

teamwork. All soldiers feel more confident because they have had first-hand experience that every soldier involved knows exactly what to do.

3. Increase the soldier's level of physical fitness. A high degree of physical fitness and health reduces the incidence of fatigue and illness, thus increasing the soldier's confident behavior.

a. Precombat actions.

(1) Conduct daily physical training with emphasis on the activities that the soldier must perform in battle. In battle, soldiers must run for short distances at a high rate of speed wearing their combat equipment, march long distances with heavy packs, and negotiate difficult obstacles. Activities such as these must be stressed because they promote real confidence through direct skill application. Activities such as running with shorts and tennis shoes without equipment, calisthenics in sweatsuits, and strength circuits may be included in a physical training program, but only as a supplement. The infantry trainer must strive to develop the ability to execute combat tasks through relevant skill training, not physical fitness through combat irrelevant activities.

(2) Insist on personal cleanliness and field sanitation, and follow up with frequent health and welfare inspections.

(3) Conduct frequent field training exercises designed to stretch the soldier's limit of endurance. These exercises should not be the "sink or swim" type, but carefully controlled exercises designed specifically to build the individual soldier's confidence. Good field

exercises help the leader and the soldier to see how everyone in the group behaves in difficult situations. This knowledge, once it is out in the open, can be used as the basis for corrective training designed to strengthen the leader, the soldier, and the group.

(4) Keep on the lookout for soldiers who are showing any psychological danger signals. These danger signals show themselves quite frequently just prior to commitment to combat and can be classified in three areas: physical, emotional, and intellectual.⁴ Physical danger signals may include chronic headache, frequent nausea or vomiting, uncontrolled trembling, or insomnia. Emotional danger signals may include extreme talkativeness or extreme withdrawal, drug or alcohol abuse, frequent quarreling, or chronic irritability. Intellectual danger signals may include confusion, frequent inattention, or sudden loss of thinking ability. The infantry leader's job is not to diagnose psychological problems. His job is to identify soldiers who are exhibiting these danger signals and to insure that they see a medical doctor. Identifying potential problems prior to combat is to everyone's advantage: the soldier gets the help he needs, the leader gets a replacement who can do the job, and the group is strengthened instead of weakened.

b. During combat actions.

(1) Lighten the soldier's load. The soldier should carry what is necessary to accomplish his mission, not equipment for every possible contingency. He must be taught to get along with less.

Soldiers must share the load of those other soldiers who have missions that require more equipment such as radio operators and machine gunners.

(2) Insist that all soldiers heat their rations when possible and insure that they have plenty of water. Emphasis must be placed on eating the complete ration, not just those items that each soldier enjoys.

(3) Eliminate all details that do not clearly serve the operational mission. Train the men to execute necessary tasks with a minimum expenditure of energy.

(4) Rotate difficult jobs such as point man and flank security. This procedure, of course, depends on a detailed cross-training program prior to and during combat.

The actions that a leader can take to increase confidence and decrease despair in relation to combat tasks can be summarized as follows: increase the soldier's confidence by teaching him to use firepower effectively, to employ tactical fundamentals in unison with others, and to keep himself physically fit.

Morale

1. A high level of group cohesion increases the soldier's confidence and decreases his tendency to act defensively. One of the most profound truths of combat is that the presence of a buddy is what keeps an infantry soldier moving forward.⁵

a. Precombat actions.

(1) Build a stable, cohesive group structure through group

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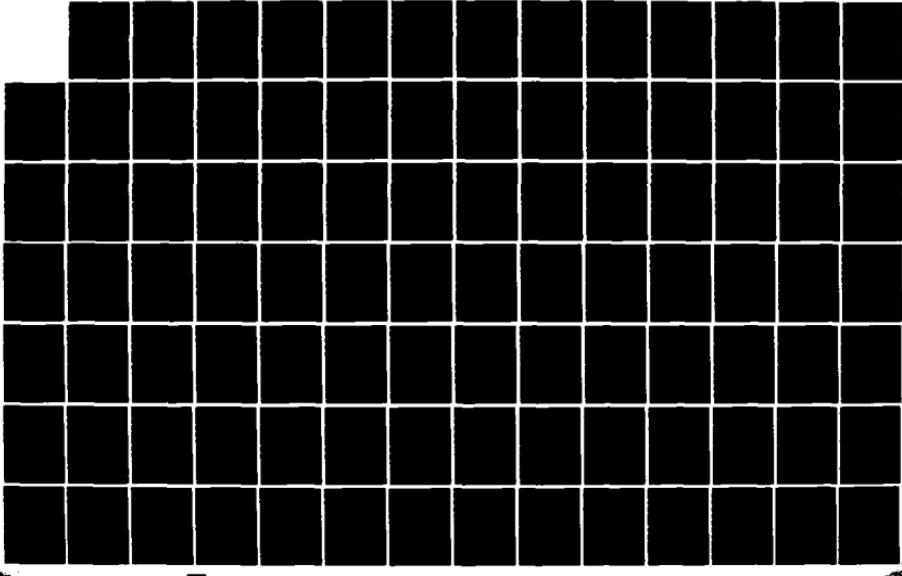
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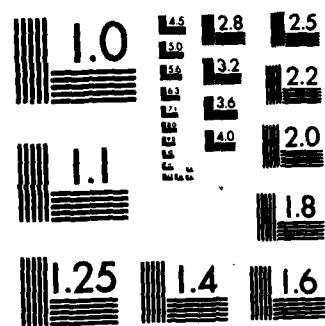
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activities, not only during training but during off-duty hours. Company parties, group athletics, and shared rewards and hardships contribute to group cohesion. The leader must always be alert to eliminate any factors that contribute to the breakdown of intergroup cooperation and unified group action.

(2) Institute a deliberate, planned reception program. In the long run, this simple activity will pay big dividends for everyone because the soldier's first few days in his unit greatly influence his attitude toward his immediate group. Emphasis must be placed on welcoming, not processing. A proper reception is even more important when a replacement is assigned during combat operations.

(3) Capitalize on unit history and tradition. Not only must the leader show the soldier how he fits into the present military unit, but he must show him how he fits into the unit's lineage and tradition. The leader must emphasize that the soldier is personally responsible for upholding the unit's honorable history.

(4) Insure that the soldier's personal and administrative problems are taken care of promptly. The soldier must be absolutely confident that no matter what happens to him, he can always depend on his military unit to support him.

(5) Stress interpersonal communication. Soldiers who talk together, fight together. Emphasis must be placed on breaking down communication barriers. The infantry leader must find out if there is any sand in the machinery of interpersonal communication and then eliminate it.

(6) Build loyalty. Once a soldier has given up some of his personal interests for the interests of the group as a whole, he expects the group, and especially the leader, to return his loyalty with their loyalty. The soldier must be convinced that loyalty is not just a one-way street; he must be convinced that loyalty is flowing in all directions.

b. During combat actions.

(1) Structure the situation. The greatest need of the soldier when he is in contact with the enemy is for some structure in his situation. Group solidarity and coordinated group action are not possible if the soldier does not know where his buddies are, what they are doing, and what the leader wants everyone to do. The leader must use every means at his disposal to structure the situation. He must make his presence known by moving to his soldiers' positions, by issuing verbal instructions, by using arm and hand signals or pyrotechnic devices, or by simply standing up and commanding "Follow Me." Emphasis must be placed on structuring the situation as soon as possible after any disorganization occurs, no matter how slight it may be.

(2) Develop buddy teams. The leader must make each soldier directly responsible for another soldier. This procedure increases cohesion and develops group identification and trust.

(3) Expose all soldiers to the same degree of threat. Emphasis must be placed on rotating dangerous jobs among all men. The existence of four or five men in the unit who are always "getting over" reduces group cohesion which, in turn, decreases individual confidence.

(4) Emphasize intergroup loyalty and dependence. The infantry soldier often finds himself facing conflicting threats. In combat, he is faced with physical harm from one direction and emotional censure by the group from the other direction. If powerful interpersonal ties exist between the soldier and his group, he will act in such a way as to avoid emotional censure from the group. Without this pressure from the group, he may contribute nothing to the group effort. The infantry leader must develop and capitalize on this peer group pressure. The infantry leader's most frequently used terms must be "we" or "us," not "me" or "you."

(5) Plan in advance for dealing with battle casualties. Because casualties always increase despair, a preplanned procedure must be instituted to deal with the casualty himself and with the other members of the casualty's group. The casualty must be given first aid, treated courteously, and evacuated promptly. Just as important, the casualty's buddies must be counseled by the leader. Talk relieves tension. The remarks of the wounded soldier's buddies are usually characterized by anger or fear. These reactions must be handled promptly. It is the infantry leader's task to assure the remaining men that their whole supporting group structure has not collapsed. Personnel readjustments must be made quickly and intelligently if group cohesiveness is not to suffer.

2. When a soldier is threatened, he feels anger, fear, or despair depending on his estimate of his ability to cope with the situation. If a soldier is angry, that is a good sign; it usually

indicates a high confidence level. The leader's problem with an angry soldier is how to direct his angry behavior in the right direction. If a soldier is apathetic and despairing, that is a bad sign; it indicates an extremely low confidence level. The leader's problem with the apathetic soldier is how to keep him alive until the battle action is over and an opportunity occurs to get him medical treatment. If a soldier is afraid, that is neither a good nor a bad sign in itself; it indicates that the soldier may go one way or the other. He may take action to eliminate the threat or he may not. It all depends on how skillful the leader is in controlling the undesirable effects of fear in himself and in others. If the leader can reduce fear levels, he can inspire effective action. If the leader allows fear to get out of control, defensive reactions, panic, and immobility may result. Fear control is a central function of combat leadership.

a. Precombat actions.

(1) Train the men on the physical effects of fear. Each soldier must know how he feels when he feels afraid. Thus, when he feels fear in combat, it will not be a totally unfamiliar feeling. The soldier must be trained to recognize fear as a normal reaction that prepares the body to respond to a threatening situation.

(2) Train the soldier to anticipate when extreme fear will occur in combat and to prepare for it in advance. Fear is greatest just before action.⁶ Fear is relatively greater when in the defense,⁷ when under artillery attack,⁸ when under bombing attack,⁹ when

attacking at night,¹⁰ when helpless to retaliate,¹¹ and when uninformed about the situation.¹² Knowing the symptoms of fear and knowing when to expect it introduces predictability into the soldier's situation and makes it possible for him to determine in advance how to cope with it.

(3) Discuss fear with the men. All men feel fear in combat. Fear is a normal, human response. The men must realize that most soldiers in combat lose their heads and exhibit ineffective behavior occasionally,¹³ that the fear of being a coward,¹⁴ the fear of killing the enemy,¹⁵ and the fear of being killed or wounded¹⁶ are normal feelings. The leader must emphasize the normality of fear feelings. An open discussion of fear can best be conducted by a combat veteran who tells the troops that he was afraid in combat, but that he dealt with it and went on in spite of it. During combat, discussions such as these are best conducted by the combat leader himself:

b. During-combat actions.

(1) Minimize the conditions on the battlefield that may be interpreted as critical. The soldier must be calmly and convincingly reminded not to make mountains out of molehills.

(2) Cultivate calmness in the men by personal example. The leader and the men must be constantly aware that the suppression of fearful behavior is critical in battle because of its contagious nature.

(3) Teach fear control techniques. A powerful method for controlling fear in combat is to concentrate on each step of the

task at hand. The men must be trained to concentrate on specific aspects of the job, not on the danger. A soldier who is concentrating on firing his weapon and on selecting his next firing position is not concentrating on fear. Once a soldier takes action to alleviate his situation, his fear will usually subside.

3. Rumors are bits of information that are not based on definite knowledge. Rumors destroy confidence because they increase uncertainty. The leader's task is to replace rumors with truth.

a. Precombat actions.

(1) Stress integrity. When soldiers discover that their leaders have lied to them once, they stop believing everything. The soldier must be absolutely convinced that all information coming from his superiors is true. Integrity is a prerequisite for mutual confidence.

(2) Institute an effective information program and disseminate as much information as possible. The men must be convinced that they are getting the whole story, the good and the bad.

b. During-combat actions.

(1) Eliminate the basic conditions that create uncertainty and frustration before they occur. Boredom and idleness are two such conditions. The leader can reduce rumors by keeping the troops busy on important tasks.

(2) Identify and counsel rumormongers. The leader must treat the spreading of rumors as a serious matter. Certainly, no

leader would tolerate a soldier spreading an infectious disease. He must have the same intolerance for rumormongers.

The combat leader's task in relation to morale is to develop group cohesion, to teach fear control, and to reduce rumor. All of these actions will increase confidence and decrease despair.

Leadership

1. Good leadership increases the soldier's confidence in himself and in his unit. The infantry leader can increase his leadership ability in many ways.

a. Precombat actions.

(1) Seek actual leadership experience. There is no substitute for this. An infantry leader whose bulk of experiences center around such activities as service school instructor, advisor duty, and staff duty can expect severe leadership problems when suddenly assigned to troop duty because of a lack of hands-on leadership experience. The infantry leader must fight for troop duty experience.

(2) Study and apply the principles of leadership. Army leadership principles¹⁷ are simple and effective. There is, however, a wide gap between these ideal principles and actual performance.¹⁸ The infantry leader's primary goal must be to apply the principles, not just to know them.

(3) Study human behavior. The study of human behavior helps the leader to know himself and his men, it helps him to understand how to control himself and others when the going gets rough, and it helps

him to influence his group so they can collectively strive toward a common goal.

(4) Study military history. There is a great deal of literature on this subject that is relevant and useful. An understanding of past combat operations supplements actual leadership experience.

b. During-combat actions.

(1) Consciously analyze leadership effectiveness. The infantry leader should be constantly asking himself pointed leadership questions. Are my actions increasing or decreasing group cohesion and effectiveness? Are my actions contributing to confident or despairing attitudes among the men? Are my actions really contributing to mission effectiveness or am I throwing up a smoke screen to make it appear that way? Not only should the leader ask these questions about his own behavior, he should ask them about the behavior of other combat leaders so he can learn from their strong and weak points.

(2) Keep in touch with the men by way of personal visits and verbal communication. The leader must insure that radio and wire communications do not interfere with actual face-to-face communication. The leader must talk to the men who do the fighting if he expects to know how they are doing. The information received from the troops is a valuable tool for evaluating the leader's leadership effectiveness. Combat inspections are extremely valuable tools. They let the leader know what is going on, and they visibly show the men that the leader is really interested in their welfare.

2. The leader must be constantly alert for confidence destroyers and despair creators both prior to and during combat. These confidence destroyers and despair creators are alive and well in many military organizations. The following are some examples:

- a. The trainer who deliberately frightens the troops with facts and figures on enemy strength and weapons capabilities, but who ignores friendly countermeasures.
- b. The training manager who puts up with false weapons qualification data rather than sending soldiers back to the range to qualify.
- c. The commander who does not insist on chemical training, electronic warfare training, and night training because of minor inconveniences.

The combat leader's task in relation to leadership is to prepare himself and his men for combat by seeking leadership experience, by developing a knowledge of human behavior, and by taking action to eliminate behavior in himself and in others that decreases confidence and increases despair. During combat, his task is to analyze his behavior by using all available feedback and to close the gap that exists between ideal and actual performance. Most importantly, he must seek to eliminate all factors in the environment that decrease confidence and increase despair.

FOOTNOTES - CHAPTER IV

¹S. Marshall, Men Against Fire (Washington, DC: Infantry Journal Press, 1947), p. 77.

²Ibid., p. 75.

³Ibid., p. 83.

⁴This classification and the examples that follow are from H. Freedman, "Mental-Hygiene First Aid for Pre-combat Casualties," Mental Hygiene, 1944, 28, pp. 192-195.

⁵Marshall, p. 42.

⁶J. Dollard, Fear in Battle (Washington, DC: Infantry Journal, 1944), p. 2.

⁷Ibid., p. 9.

⁸Ibid., p. 14.

⁹Ibid.

¹⁰L. Kahn, "A Discussion of Some Cases of Operational Fatigue in the Army Air Forces," Psychological Bulletin, 1947, 44, p. 49.

¹¹Dollard, p. 9.

¹²Ibid.

¹³Ibid., p. 4.

¹⁴Ibid., p. 18.

¹⁵R. Grinker and J. Spiegel, Men Under Stress (New York: McGraw-Hill, 1945), p. 43.

¹⁶Dollard, p. 18.

¹⁷Department of the Army, Military Leadership (Washington, DC: Department of the Army, 1973), pp. 2-1 to 2-13.

¹⁸S. Stouffer, et al., Studies in Social Psychology in World War II, Vol. 1, The American Soldier; Adjustment During Army Life (Princeton, NJ: Princeton University Press, 1949), pp. 386-88.

CHAPTER V

PANIC AND ISOLATION

In combat, there are many situations that give rise to individual despairing behavior. The well prepared leader can cope with these individual behaviors as they occur. A much more complicated and difficult leadership problem exists, however, when group despairing behavior occurs. Group despairing behavior usually takes two general forms: group panic or group withdrawal from reality.

Panic occurs when a group of soldiers believe that as a group they cannot cope with a threatening situation and that they are becoming trapped.¹ Panic is characterized by intense fear, heightened suggestibility, and fleeing from the battlefield.

Group withdrawal from reality occurs when a group of soldiers believe that as a group they cannot cope with a threatening situation and that all escape routes are closed.² Units isolated far behind enemy lines are a good example of this situation. Despairing behavior when isolated on the battlefield is characterized by inaction, apathy, and hopelessness.

Panic

There are three conditions that must exist on the battlefield for panic to occur. The conditions can occur over an extended period of time or they may occur simultaneously. If the leader can eliminate

any one of the three conditions, he can eliminate panic. The three conditions are:

1. A belief by the group that all escape routes are rapidly closing.³
2. The existence of an immediate threat or an ambiguous situation that invokes a feeling of helplessness and anxiety.⁴ The following threats and ambiguous situations have led to military panics in the past:⁵
 - a. Breakdown of communication or organization.
 - b. Conflicting orders.
 - c. Prolonged waits under tension.
 - d. Frequent false alarms.
 - e. Unexplained retreats.
 - f. Death of a charismatic leader.
 - g. Threat to a flank.
 - h. Threat to supplies.
 - i. Surprise.
 - j. Unexpected enemy weapons.
 - k. Defeat.
 - l. High casualties.
 - m. Disorderly retreat.
 - n. Being lost.
 - o. Not knowing the position of the enemy.
 - p. Low firepower or low ammunition supply.
 - q. Physical exhaustion.
 - r. Baptism of fire.
 - s. Rumor.
 - t. Dissension between leaders.
 - u. A leader dramatically expressing his fear.

3. A trigger incident that confirms the group's belief that the situation is beyond their control.⁶ One soldier may flee to the rear, firing may come from an exposed flank, or a respected leader may be killed. Trigger incidents like these give the group the opportunity to structure the situation in a way that confirms their worse suspicions. In addition to this, there is a tendency among combat troops to relate all previous and subsequent information to the trigger incident. For example, if the trigger incident was an exceptionally heavy artillery barrage in the friendly rear area, the overdue arrival of an ammunition party from the rear may be interpreted as evidence that the ammunition point has been destroyed. The trigger incident and other reinforcing evidence leads to an uncontrollable fear that if communicated among the group may lead to the hysterical behavior of one or more of the group's members. If one soldier flees to the rear, group action may follow. Other soldiers may follow the fleeing soldier, and such actions may snowball until the entire group is in flight.

When considering these three conditions, the cognitive aspect is of critical importance. If the soldiers believe that their escape routes are rapidly closing, if they believe that ambiguous situations are a prelude to uncontrollable events, or if they believe in their most pessimistic appraisals, then the seeds of panic are firmly planted. It is what the soldiers "think" is true that counts, not what is actually true.

Soldiers in combat are regularly exposed to death and battle

wounds. They are subject to all of the fears that lead to panic. Experienced troops who are well trained, organized, and led seldom give way to panic because they are confident in their ability to cope with difficult situations. The reverse is true for inexperienced, inadequately trained, and poorly led troops. In either case, the infantry leader must constantly evaluate the confidence level of his unit and strive to increase troop confidence, to eliminate the conditions that lead to panic, and to decrease troop despair. The leader can prevent panic in combat by taking the following measures:

1. Assure the troops that they are not being backed into a corner. If the troops believe that many escape routes are open, panic is less likely to occur.

2. Downplay threatening situations by:

- a. Setting a personal example of fearlessness⁷ and insisting that subordinate leaders do the same.
- b. Explaining the reasons for withdrawals and delaying actions.
- c. Stressing the group's collective ability to cope with all battlefield situations.
- d. Assuring the group that their flanks, rear, and ammo supply are secure.

3. Structure the situation constantly by:

- a. Keeping the group organized and functioning. The leader must take all possible actions to keep the group from disintegrating. When the group is disrupted, preoccupation with individual physical survival develops, and the attraction to remain a member of the group

is minimized.⁸

b. Using the chain of command whenever possible to avoid the possibility of conflicting orders.

c. Managing time efficiently to prevent prolonged waits.

d. Avoiding false alarms.

e. Training subordinate leaders to immediately take command in the event of death or incapacitation of their leader.

f. Preventing surprise by stressing security.

g. Keeping the troops informed on all matters, especially on their own location and on the enemy's location.

h. Never expressing dissension in the presence of the troops.

i. Forcefully counseling those soldiers who are increasing fear by irresponsible talk. A soldier who is inflating the accuracy and lethality of enemy weapons or exaggerating the strength of the enemy increases troop despair; he must be warned about his irresponsible behavior.

4. Be on the alert for incidents that the troops may interpret as critical. When trigger incidents occur, prompt and calm action by the leader must follow. He can:

a. Keep the troops busy with a routine task that is simple and repetitive. If the troops are concentrating intently on a routine task such as firing their weapon, they will be paying less attention to their own fears.⁹

b. Move from position to position, reassuring the soldiers that the situation is not critical. When the leader does this he not only reassures the men, he also adds structure to the situation.

c. Slow the troops down so they can act instead of react.¹⁰

This is especially important if the troops are showing early hysterical behaviors such as extreme agitation or extreme confusion.

If panic develops in spite of all of the leader's efforts, firm and decisive action must be taken to stop the panic as early as possible. Unity of action can often be restored by the leader of a few volunteers who stands in the path of flight and orders the fleeing soldiers to turn back, without hesitating to manhandle or restrain those men who come within reach or to threaten the others with weapons.¹¹

If the flight to the rear continues, the leader may shoot over the heads of the fleeing soldiers and, as a last resort, shoot at the fleeing soldiers with the intent to incapacitate, not to kill.¹² The overriding consideration is that the panic must be stopped.

Once the panic is stopped, the leader must structure the situation immediately and give the panicky soldiers something constructive to do as part of a larger stable group. The work will distract them from their fears and the stable group will increase their confidence.

Isolation

When a unit is cut off and surrounded in combat, special leadership problems develop. Because escape routes no longer exist, the "running away" type of panic behavior seldom occurs.¹³ Instead, the soldiers' behavior can best be described as apathetic.

Combat isolation is an exceptionally serious problem. The leader must counteract the feeling of isolation by aggressive action aimed at

convincing the troops that alternatives are available and that hope is not lost. In other words, he must persuade his men that there are positive solutions to their present problem. Most of the actions described previously to prevent panic are applicable to an isolation situation. The following actions are especially important for reducing the effects of isolation and for raising confidence:¹⁴

1. Restore communications with higher headquarters. Contact with the parent unit links the isolated unit to the combat power of the rest of the military force.
2. Talk and act confidently. Self-pity and defeatism only increase apathy.
3. By personal contact, assure the soldiers that all possible actions are being taken to extricate them from their present situation.
4. Stress actions oriented toward ending the isolation. Rehearsing breakout plans is an example of such an action. This will help to maintain aggressiveness and to reduce the incidence of rumor.

Summary

Groups of soldiers act differently in different situations when they are extremely afraid. Panic occurs when a group of soldiers believe that their escape routes are rapidly closing. When all escape routes are perceived to be definitely close, troop behavior becomes apathetic and hopeless. Panic can be prevented. However, if it occurs, the leader must take firm and immediate action to stop it. Isolation

on the modern battlefield cannot always be prevented, but apathetic behavior can be prevented by confident, aggressive, and dynamic leadership.

FOOTNOTES - CHAPTER V

¹E. Quarantelli, "The Nature and Conditions of Panic," American Journal of Sociology, 1954, 60, p. 267.

²Ibid., p. 278.

³N. Smelser, Theory of Collective Behavior (New York: The Free Press of Glencoe, 1963), p. 139.

⁴Ibid., pp. 140-142.

⁵a. Examples a. through o. are from: National Research Council, Psychology for the Fighting Man (Washington, DC: The Infantry Journal, 1943), pp. 394-395.

b. Examples p. through r. are from: Department of the Army, Military Leadership (Washington, DC: Department of the Army, 1965), pp. 41-43.

c. Examples s. through u. are from: J. Green, ed. The Infantry Journal Reader (New York: Doubleday, Doran, 1943), pp. 279, 287 and 277, respectively.

⁶Smelser, p. 147.

⁷L. Pennington, R. Hough, and H. Case, The Psychology of Military Leadership (New York: Prentice-Hall, 1943), pp. 235-238.

⁸D. Schultz, "Panic in Organized Collectivities," Journal of Social Psychology, 1964, 63, p. 357.

⁹W. Hocking, Morale and its Enemies (New Haven: Yale University Press, 1918), p. 165.

¹⁰Ibid., p. 166.

¹¹Department of the Army, Military Leadership, p. 42.

¹²Ibid.

¹³Quarantelli, p. 273.

¹⁴Department of the Army, Military Leadership, p. 43.

NOT USED

IW + OW = CF: THE FORMULA FOR STRESS MANAGEMENT

Alfred M. Coke, Ph.D. and Michael D. Mierau

THE FORMULA

The corporate fitness (CF) of any organization is dependent upon two principal factors. The first factor is the psychological and physiological wellness of its members (IW). The second factor, organizational wellness (OW) is a measure of how efficiently an organization uses its resources. The final outcome of the formula $IW + OW = CF$ is organizational effectiveness, which translates into getting the job done.

THE PROBLEM

Extensive studies have been done on individual stress, little on organizational stress. Supra-achieving organizations are dependent upon high performing people filling their ranks. High performing people likewise are dependent upon supra-achieving organizations to provide outlets for creativity through work. The classic Catch 22 is in place. One can't exist without the other. One can't be studied without examining its relationship to the other. The problem is how to study the stress of an organization from a corporate view without neglecting its most critical resources - people.

THE MODEL

What is necessary to solve the stated problem is a non-medical, practical plan for the management of stress using systems theory. Such a framework exists in the Stress Models Integration and Linkage Efforts (SMILE). This plan was developed over the course of three years. It is current in technology and appropriate for all levels of society. It has been tested with audiences ranging from housewives to Chief Executive Officers. It is not a panacea to stress resolution. It is a stress management plan based on easily understood human principles and adaptable management concepts.

The SMILE is a systems approach that permits the analysis of stress from its root sources. Those are personal, occupational, organizational, and environmental. In most stress literature these are so intertwined that they are confused. The SMILE is described in terms of interacting subsystems that can be studied. It is drawn as an equilateral triangle for visualization. The basic theory of the subsystems' relationship found in the triangle is that it conforms to the Universal Law of Homeostatis or the principle of balance. When all three subsystems are functioning with precision, harmony is in effect. The triangle is said to be in balance.

Often events and conditions upset the balance of the system. In other words too much or too little stress is occurring. This imbalance can be effectively managed. If not, the accumulated effect of constant imbalancing results in personal illness and organizational dysfunctionality. They are the same reaction to stress.

The SMILE plan describes basic and advanced skills for the management of all types of stress. Recovery, prevention and maintenance of stress is emphasized as basic skills. Advanced skills permit the user to develop psychological hardiness through control, commitment, and challenge. These learnable skills provide the springboard to manage stressful situations at higher levels of awareness. The model discourages stress reduction cultism, advocates a balanced program of stress management, and describes active measures rather than reactive behavior toward stressors.

Stress can be dealt with through proper training of individuals for personal wellness and management analysis by leaders who seek corporate fitness. Personal stress management of chemical, structural, and mental factors produces the synergy of individual wellness. Organizational wellness results from combining proven management principles with mission, structure, and resources factors to produce balance. Individual wellness plus organizational wellness results in a fit corporation.

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2. _____, Strategies for Corporate Fitness, (Virginia Beach, VA: Impact Publications, To Be Published Fall, 1982).
3. _____, The Trainers Manual for Individual and Corporate Fitness, (Virginia Beach, VA: Impact Publications, To Be Published Fall, 1982).

PSYCHIATRIC SUPPORT SYSTEMS IN THE THEATER OF OPERATIONS (CBSR)

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OVERVIEW

This block of instruction was designed and presented to RACH personnel during their annual FTX. Delivery time is fifty minutes allowing ten or more minutes for discussion purposes.

With the idea of adding some realism and stress to the presentation of condensed tape of an actual rocket and mortar attack (TET offensive, 1968 RVN) was incorporated. The numbers of soldiers within the military who have experienced the rigors of a combat environment are steadily dwindling. Inclusion of the sounds of combat coupled with the voices of troops under stress can be a very effective method of allowing participants to get in touch with their own internal anxiety and coping mechanisms.

Finally, this presentation was drafted and presented on a trial basis. Additions, changes and deletions are taking place in the hope of establishing a combat stress program which could be presented to Fort Sill combat arms units and training schools.

GENERAL INFORMATION

In World War I shell shock was a legitimate physical disorder thought to be secondary to effects of concussion from artillery. Three of four surviving combat infantrymen left combat in this manner. About 76%. At one point the rate of discharge from military for psychological effects of shell shock was greater than the rate of induction of new soldiers. Later studies indicated that many of these infantrymen were not exposed to close artillery fire.

In World War II the rate of psychiatric casualties was about 1/1000 per day among combat infantrymen. These casualties were called combat war neurosis. This terminology conveyed to doctor and patient that the individual suffered some permanent mental disorder.

The lowest rate of psychiatric casualties and lowest rate of long-term effects occurred during Vietnam. This low rate resulted in part from careful study of stress in combat and application of the appropriate treatment measures.

This block of instruction is on psychiatric First Aid and the combat stress reaction. These are not really separate topics. The psychiatric care that we all would be involved in in a combat environment would almost exclusively consist of prevention, recognition and treatment of combat stress reaction. You may be familiar with similar terms for the same syndrome such as battle fatigue or combat exhaustion. Hopefully, thinking of this syndrome as a stress reaction will convey a mental image or attitude of a temporary disability rather than a permanent psychiatric condition. One that is caused by a combination of a wide

variety of stresses an individual faces in combat such as personality factors like motivation, social factors like morale, physical-environmental stresses like fatigue and psychological stresses unique to combat.

COMBAT

ENVIRONMENT

You are there!

1. Imagine that each of you are assigned to an evacuation or combat support hospital in the theater of operations.
2. Enemy fire is in the vicinity but distant.
3. Communications are knocked out.
4. It has been reported your neighboring hospital has been hit by a nuclear explosion and all are rumored to be dead.
5. Casualties are describing enemy air drops 3-7 kilometers distant and moving in your direction.
6. Combat troops along with civilians are streaming past your hospital.
7. Small arms fire has become increasingly more audible.
8. Friends and co-workers have been killed and wounded.
9. Artillery barrage has intensified with shells exploding in the hospital area.

COMBAT STRESS

OBJECTIVES

1. Understanding the central battle scenario.
2. Preventing yourself from becoming a CBSC.
3. Understanding current doctrine concerning triaging.
4. Becoming familiar with the present and proposed evacuation process of CBSC and psychotic/schizophrenic individuals.

5. Becoming familiar with the treatment process.

 Immediacy.

 Proximity.

 Expectancy.

 Simplicity.

6. Treatment concepts.

7. Three stages of Kern's model of stress.

8. What medical staff need to know concerning CBSR.

9. Recommendations.

I Central Battle Scenario

1. Mass of firepower.

2. Large number of assault troops in a relatively small area.

3. Shock, surprise, mobility.

4. Hit and run, highly mobile and fluid.

5. Penetrate, move to division rear and corps areas. Disrupt support and service support elements.

6. Use of airborne troops, chemical, lasers and microwaves.

7. High intensity continuous day and night. Increase lethality. Tactical nuclear weapons in these areas to kill and disrupt.

8. Tactical purpose is primarily aimed at the production of very high psychiatric casualties, as well as immobilization of forward maneuvering elements.

9. Projected; a CBSC WIA ratio of 3-1. It may be as high as 50% of all wounded, or in some cases equal or exceeding the number of wounded.

10. Highest ratio of CBSC to WIA will be seen among support troops. Highest rate among combat troops.

11. CBSC of BFC will be largest readily available source or replacements in force reconstitution.

II Preventing Yourself from Becoming a CBSC

1. Training.

- a. FTX.
- b. Exposure to sights, sounds of warfare.
- c. Familiarization with offensive and defensive combat roles.
- d. Be thoroughly knowledgeable about your MOS/SSI.
- e. Learn an alternate MOS or SSI.

2. Rest.

- a. Practice continued high-paced work performance on four or less hours of sleep.
- b. Incorporate use of relaxation principles and techniques.
- c. Do not overexert yourself. Pace yourself. Conserve energy both physical and emotional.
- d. Take time out to eat and drink. Maintain nutritional levels to reduce fatigue and restore energy levels.

3. Discipline.

- a. Act upon fact not rumor.
- b. Idleness, keep yourself occupied.
- c. Maintain personal hygiene, sanitation.
- d. Keep clothing clean and in order.
- e. Recreate.
- f. Keep up physical fitness program.
- g. Keep in touch with home, maintain contact.
- h. Isolation heightens stress.

4. Personal Problems/Stresses.

- a. Family life.
- b. Financial.
- c. Marital relations.
- d. Ability to withstand change.
- e. How flexible a person are you?

5. Group Cohesiveness.
 - a. Maintain individual identity.
 - b. Associate with peers.
 - c. Comradery is built and maintained by a group sharing similar experiences.
 - d. Discuss the loss or death of comrades - reduces anxiety.
 - e. The lower the degree of unit cohesiveness and the higher the prevalence of life stresses among individuals within the unit, the greater the likelihood the unit will experience high CBSC rates.
6. Leadership.
 - a. Is a primary responsibility of officers and senior NCO's.
 - b. Be prepared to assume leadership positions especially in times of crisis.
 - c. If prepared to assume a leadership capacity anxiety can/may be reduced when an individual is confronted, thereby reducing stress.
7. Environment.
 - a. Severe weather conditions or climates will enhance stress victims.
 - b. May complicate CBSC treatment.
 - c. Quite possible to produce extreme numbers of specific types of CBSC, i.e., heat or cold victims.
 - d. Length of, severity, and extent of brutality of combat will produce severe CBSC.

III Current Doctrine

1. Defines role of mental health personnel as primarily evaluating, consequently over-evaluation and over-hospitalization occur.
2. Does not reflect treatment principles of immediacy, proximity, expectancy and simplicity.
3. Does not take into account large projected number of psychiatric casualties.
4. Current system not flexible enough to provide adequate support to predicted casualties in theater support area (corps and commz).
5. Finally, provides a system for traditional psychiatric casualties but not for the CBSC or BFC who requires a separate system.

IV. A. Present Evacuation Process.

1. Primarily an evacuation system.
2. Combat psychiatric casualties evacuated through BAS, FWD CLR, REAR CLR, EVAC HOSP, and out of the CORPS.
3. Once patient crosses division boundary he/she lost to unit.
4. Current configuration in the division calls for 15-17 BAS, 3 FWD CLR STA and 1 REAR CLR station.
5. This system places the most forward 91G (Behavioral Science Specialist) personnel at the FWD CLR station.
6. Mental health professionals; psychiatrists, psychologists, social workers and 91G personnel are found at the division rear CLR station.
7. This system, based on experience can return about 70% of CBSC casualties to their units on a conventional battlefield. The remaining 30% are lost. A large proportion are lost to duty.

B. Proposed Evacuation Process (Designed primarily for the 1986 heavy division. It has application for the light division as well.).

1. The emphasis concerning CBSC in the battalion, brigade and division rear areas will be upon the early return of the casualty to his/her unit or duty elsewhere, not evacuation.
2. Mental health as well as other medical personnel act as "evacuation interrupters," not as "evacuation facilitators" unless indicated.
3. Triaging of casualties will begin at the unit level.
 - a. Buddy or unit personnel first to recognize and treat symptoms.
 - b. If the symptoms persist 91B personnel at BAS will treat.
 - c. Further evacuation to FWD CLR station where 91G personnel will treat or evacuate rearward.
 - d. REAR CLR station. If individual is psychotic/schizophrenic or a severe CBSC they will be retrograded to the EVAC HOSP. If patient is CBSC they will be directed toward the restoration center.
 - e. Individuals arriving at the EVAC HOSP will either be treated or further retrograded out of the corps area to the command and eventually out of the theater of operations.
4. At the FWD CLR station treating, consulting, and technical supervision will be provided to BAS by mental health personnel.

5. At the rear clearing station it will be the psychiatrist's task to approve any further rearward evacuation of the casualty. Casualties directed toward the restoration center will return to duty within approximately 168 hours, but not necessarily with their original units. They may be given combat support, or service support missions.

6. Corps Level.

a. Anticipated high CBSC rates for theater support area (corps, rear and commz) due to long-range shelling with explosives and chemicals.

b. The restoration center will provide psychiatric support to the corps rear and commz.

c. This center will be designed to provide a soldiering milieu instead of a hospitalized patient setting.

d. The clearing company will be given treater personnel similar to the division clearing companies.

e. Severe CBSC will be evacuated to the evacuation hospital. Less severe (returnable) CBSC will be routed to the restoration center for eventual return to duty.

f. At the present time, it is not clear who will staff and manage these restoration centers. However, this patient management system is more flexible for changing tactical situations, closer to the supported troops and more adequate for the expected increase in casualties.

7. This proposed concept for management of CBSC and psychiatric patients offers the following:

a. Defines mental health personnel as "evacuation interrupters."

b. Reflects treatment principles.

c. Accounts for larger numbers of battle fatigue/CBSC.

d. Flexible enough to provide theater support and area support.

e. Provides a system for both traditional psychiatric and BF or CBS casualties.

V Treatment Process.

1. Immediacy.

2. Proximity.

3. Expectancy.

4. Simplicity.

a. **Immediacy** = Treat CBSC not as a patient or "sick" individual. Remove from stressful event, find shelter, talk with soldier, reassure. Rest if possible. Unit and 91B level personnel will treat.

b. **Proximity** = Treatment should occur as far forward as possible. Only evacuate those who are severe. The further rearward the patient is evacuated the greater the likelihood of internalization of illness; "I'm a patient, therefore I'm sick." Guilt tends to become more pronounced the further to the rear he is evacuated.

c. **Expectancy** = Emphasis by all health care providers must be upon the eventual return of the soldier to his job. No individuals suffering from CBS should be idle. Emphasis upon soldiering tasks should be paramount.

d. **Simplicity** = Treatment principles must not convey illness, or sickness. Insure the patient of the normalcy of his behavior. The patient is not suffering from a permanent mental disorder. Rest and recreation, food, normal soldiering tasks, ventilation, support from friends or peers, along with emphasis upon return to duty or combat must be implemented prior to the introduction of therapies requiring psychiatric intervention.

VI Treatment Concepts.

1. Think combat stress reaction first rather than schizophrenia or other mental disorders.

2. Avoid hospital environment terminology or treatment that would convey a permanent mental disorder.

* Segregate from WIA's - guilt = symptoms.

(Expectancy)

3. Be alert for increasing stress in yourselves and those who work for you.

Exhaustion, confusion, anxiety.

Drop in efficiency.

(Immediacy)

4. Manage preventive measures. Morale, leadership, motivation, cohesion, physical needs, environmental stresses, personal problems, training, confidence, experience.

5. Enforce sleep discipline if projected situation exceeds 48 hours.

6. Exhaust simple treatment measures first. Rotation to a non-combat task in the unit, food, rest, shower, opportunity to ventilate.

(Simplicity) Brief - 48 hours 70%
96 hours 20%.

7. Avoid major tranquilizers - may increase lethality of some nerve agents.

8. Be alert to wide overlap of environmental injuries and stress reaction. Frostbite is often a legitimate way out of a combat situation. On the other hand early legitimate environmental injuries may be confused with combat stress reaction.

Hypothermia	Mute	Heat Stroke	Delirious
	Stuporous		

Treat cases like combat stress reaction.

VII Kern's Three Stages of Stress.

Stage 1. Individual oriented toward external cues. Individual attempting to manipulate and control the environment. Soldier learns how to perform as expected - minimizing exposure to danger. He also reaches maximum effectiveness.

Stage 2. Soldiers behavior turns more and more towards self-preservation. He perceives himself as in a situation having little or no control. Job performance begins to diminish.

Stage 3. Rather than responding to external stimuli, the soldier's attention is directed towards internal stimuli. Attempts to control the environment through job performance tasks declines rapidly. Self-preservation likewise declines. Behaviorally, the soldier will appear apathetic to the point of failing to take appropriate cover and/or concealment.

VIII What Medical Staff Need to Know Concerning CBSR.

1. In past wars by and large medical units for the most part were not targeted directly for destruction.

2. The hospitals or facilities you may find yourselves working in within the division or corps will be targeted for disruption at best or destruction at least.

3. Your jobs may not only have to be performed in harsh weather conditions but with the added danger of laser, microwave, radioactive fallout, and/or biological or chemical contamination.

4. The type(s) of combat coupled with sophisticated weaponry and the potential for the production of large numbers as well as many different types of casualties, will proportionately increase the likelihood that medical personnel will themselves become CBSR.

5. Medical staff must be able to recognize the signs and symptoms of stress not only in themselves, but in personnel either associated with them or who work for them. Treatment should be the same as for any other person experiencing the same.

6. Medical staff must be able to differentiate between casualties needing legitimate hospitalization or treatment at a restoration center.

7. Very often environmental casualties will present themselves as stress victims and vice versa. The distinction between the two can often be made by taking and observing vital signs.
8. Any CBSC generated either in your facility or in a combat role can be put to work at the hospital until symptom reduction or elimination has occurred.
9. When and where possible medical staff (including support and/or ancillary personnel) should be allowed to perform different functions to help reduce the effects of stress.
10. Medical staff not only need to be aware of their own response and coping abilities to stress but must be thoroughly knowledgeable concerning their ability to teach the concepts, techniques and treatment methods to the soldiers they support.

IX Recommendations.

1. All medical units incorporate in their annual FTX a simulated combat environment to include multiple movement of the installation and personnel, simulated casualties, simulated attacks, night movements, and the incorporation of enough physical and mental effort to bring on fatigue. Personnel should become exposed to constant work on four hours or less sleep in a twenty-four hour period of time.
2. Complete combat scenarios for medical units should be incorporated at Fort Irwin, California. Such an environment would allow soldiers in these MOS's or SSI's to become more knowledgeable about how they respond under simulated combat conditions.
3. Many military training schools and installations have programmed little or no time for teaching CBS topics, coping mechanisms, or treatment techniques. It is envisioned that if given command directive and support, teaching programs could be developed and taught by CMHA or divisional social workers in coordination with organizational effectiveness personnel in Officer Basic and Advanced Courses, battalion and battery or company level cadre, and any additional attached or support units.

OCCUPATIONAL THERAPY

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Historically, Occupational Therapy (OT) has been involved in the war effort. One of the first training programs for OT was through the military where OTs would be used in the rehabilitation of disabled soldiers and civilians. During World War I, OT was an integral part of Base Hospital #117 in France which returned a large percentage of its soldiers to duty in some capacity.

At the present, OT in the Army is primarily hospital-based with a definite shift to the community taking place. The Stress Management Program at Fort Bragg and the Hale Nui Program at Schofield Barracks are examples of this shift. At Fort Hood, the ABLE (Army Barracks Learning Environment) program is exploring the possibility of skill development in a barracks environment.

Currently, the MACRIT study defines the role of OT in the theater of operations primarily in the areas of splinting, burn treatment and hand evaluations. The study identifies the need for OT at the 300-bed Station Hospital. A proposal for the role of OT in the mental health arena is in the working stage. One of the unique contributions of OT in the theater of operations is an expertise in bio-medical as well as bio-social intervention and restoration.

OT helps an individual (soldier) build and rehearse competency skills. These skills can be used to prevent or reduce stress. A stressed soldier can ventilate and metabolize the stress ("fight or flight") hormones through activity and task involvement.

A fully effective soldier is a competent soldier.

NOT USED

SIMULATION OF COMBAT STRESS CASUALTIES
BY LIVE ROLE PLAYERS AND "CONSTRUCTIVE
(PAPER) CASUALTIES"

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1. The ARTEP system and many other training programs, as well as the Academy of Health Sciences resident courses, require the teaching and evaluation of the complex skills involved in sorting, managing and treating large numbers of combat stress casualties mixed with a few other, more serious, neuropsychiatric or character disorders. Simulation exercises, preferably ones which utilize live role players in relatively naturalistic surroundings, are the most effective way of reinforcing and testing this knowledge. However, experience has revealed a number of common problems in such simulations. This paper reports some ongoing efforts at the Academy of Health Sciences to develop an improved system for using both live role players and written "constructive cases."
2. Usual problems in conducting combat stress casualty simulations include the following:
 - a. Live role players are often hard to obtain and may be demographically unrepresentative (e.g., younger, more females, etc.).
 - b. The exercise controllers must choose suitable roles and train the players to act them. Some symptom complexes are hard to play.
 - c. There is a natural tendency (especially with a small number of cases) to select dramatic, high pathology "problem cases." The role players themselves often drift towards "crazy behavior" out of boredom or to maintain the triager's interest. Role players even have become violent enough to suffer or cause damage.
 - d. Relatively long processing time is required for the triager to interview live patients; this decreases the number which can be seen in an exercise lasting only several hours.
 - e. With only a small number of cases (some of them intentionally selected as "problem cases" for management or differential diagnosis), a distorted impression is given of the types and relative frequencies that are likely to be seen.
 - f. The exercises rarely give "longitudinal" middle and long-term feedback on the appropriateness or inappropriateness of dispositions or treatment plans. Such feedback which is attempted is difficult to manage and standardize.
 - g. On the other hand, purely didactic lectures or simulations using only written case histories or "card sorting" triage tasks are likely to be approached with a detached, "academic" mind set, and do not arouse the same anxiety or call for the same skills as interacting with a real, unpredictable human being.

3. What we perceive is needed is a standard system:

- a. Which utilizes live role-players (of whatever type are available), augmented with "constructive cases" (written descriptions of cases).
- b. Which can provide progressive feedback on the basis of what successive actions the Mental Health Officer (MHO) or other student makes over a simulated period of several days.
- c. Which promotes a realistic appreciation of the problem by presenting a valid spectrum of the types and relative frequencies of cases.

4. Origins of the present approach:

- a. The Fort Knox CMHA's Project COPE simulations included a card sort triage task concurrently with "live casualty" play. Each card had only a simple one or two line description or chief complaint, which often did not give enough information for a valid triage decision. The card stack was also presented en masse, rather than as part of the simulation's patient flow. Consequently, the task served more as a diversion or an additional stressor in the exercise rather than as a true test or learning experience.
- b. A similar card sort task was used in our first Officers' Advanced Course exercise. Efforts to provide feedback on the appropriateness of triage dispositions foundered over the different interpretations of the one-two sentence descriptions and the need for more information. There were also practical problems of "scoring" the card sorts in real time.
- c. Concurrently, we wrote several combat stress role-player scenarios for USUHS/Combat Care Casualty Course (C4) field simulations. We also discovered how those roles were changed, sometimes dramatically, when played by eager but inexperienced enlisted persons. These cases involved more description of each case. Those written for the C4's also specified physical findings and past medical history (to be given only if solicited by the triager), plus an evaluator's checklist of how the case was handled.
- d. I (JWS) also read the Div Med Bn ARTEP, which has an appendix for the med/surg evaluation (not for the Div Mental Health Section) which gives a method for use in grading the handling of constructive cases. Constructive cases are written on a printed form which is handed to the testees but is then to be treated in real time as if it was a real casualty, i.e., put on a stretcher, carried from place to place, have its simulated vital signs or X-ray taken, etc. The evaluator provides the follow-up information and writes down clock times and go/no go evaluations of how well the case was managed.

5. Synthesis: We have developed sufficiently detailed descriptions of the appearance, chief complaint, obtainable history of present complaints and relevant medical notes for a variety of combat stress and neuropsychiatric cases. Five cases (labeled alphabetically), with their action checklists on the reverse side and their associated "Further Developments" feedback instructions, follow this paper. Each case can be the basis for live role play or can stand alone as a constructive case. In either situation, we do not try for real time handling. Rather we allow time compression during the management of each case (independently of other cases). Each case is initiated into the patient flow and followed through as many "Stages" as are appropriate.

a. Stage I is the initial evaluation. The MHO gets the history (from the printed form or by interviewing the role-player) and specifies the action to be taken. This can be one of the possibilities listed on the form, i.e.,

- (1) Return to duty (RTD).
- (2) Return to unit trains for rest and replenishment before RTD.
- (3) Return to unit for admin action.
- (4) Return to Med Clearing for further medical evaluation.
- (5) Hold for rest, replenishment and RTD.
- (6) Hold for rest, replenishment and observation.
- (7) Hold for evacuation as soon as possible.

(8) Evacuation (can be accomplished only when transportation is announced as a later stage).

b. The evaluators receive the form back, compare the action chosen with a prepared set of "developments" for each action, and write these developments into the form. If indicated, they also brief the role player on how to act in the next stage. If the disposition was correct and definitive (i.e., return to duty of a soldier without contradicting symptoms), the case may be closed. Otherwise, he/she/it is reintroduced into the patient flow as if some hours have passed. For example the case may have been returned by his unit as "still too sick," or has been medically cleared, or has slept eight hours and gotten a hot meal, or can now be evacuated in the ambulance which is loading up, or whatever. Results of special tests or inquiries are also written in. It is now Stage II.

c. At Stage II, the MHO must re-evaluate based on the new developments and choose which one of the same list of actions is appropriate at this time.

d. The process continues through successive stages until the case is either "returned" somewhere that does not send him/her/it back, is evacuated, or the exercise ends.

e. Administrative demands, communications/consultations play, etc., can also be introduced whenever desired.

6. The advantages of this synthesis are as follows:

a. The presence of live role-players (following fairly well-described roles) stimulates the emotional involvement and anxiety of the MHO's and exercises their patient-handling and interviewing skills.

b. The constructive cases provide variety and demographic normalization without requiring too much time (NOTE: live and constructive cases may be waiting in queue to be seen and the triager must decide which to process first based on initial impressions).

c. The "time compression" amounts to taking most of the "blank audio tape" out of each case, such as the time they are away somewhere else, sleeping, being treated in group by the 91G, etc. The rationale for this is that the MHO would in reality be dealing continuously with longitudinal cases at different stages: triaging new cases, re-evaluating ones he admitted yesterday or the day before, etc. In such situations, his/her sense of time may well become distorted anyway. This technique allows that process to be condensed into a few hours while giving the kinds of feedback that would be obtained over several days.

7. We are continuing to refine the format and feedback system and to increase the number and variety of cases. Eventually we intend to package this for "export to the field." The package would include "Chinese restaurant menus" ("Take 5 from Column A, 3 from Column B, 1 from Column C, . . .) which would specify appropriate mixes of cases (and the appropriate actions for each case) at different levels in the evacuation chain from aidman through Division Mental Health Section. The possibility of using audiovisual aids to supplement the constructive cases and to help train the role-players is also being evaluated.

8. Sixteen cases are presented below, with their associated Further Developments feedback instructions for the controller/evaluators. Some also have a commentary of "Teaching Points and Judgment Calls." The Action Checklists are printed on the reverse side of each case; they can be folded over (and stapled) to conceal the History of Present Condition and Past Medical/Social History sections until after the triager decides to investigate this case further. An Action Checklist with no alphabetic case I.D. on it has also been included; this can be copied and used to record actions for the live role-players (after writing in the role's appropriate I.D.).

9. We welcome comments and especially any experience in using these cases in field or didactic settings, both in the live and constructive modes. Obviously the details of these cases (racial origin, gender, etc.) should be modified to suit the available role-players, give demographic balance, and avoid exact repetition for the same audience. Totally new cases, illustrating different aspects or conditions, should also be added. We would be happy to receive copies of any that you create.

CASE A

19-year-old black male E-2 infantryman evacuated by ground ambulance from the company aidman via Bn Aid Station and Bde Clearing Station and sent over to you from Med Clearing.

Field Medical Card: "Combat Stress Reaction, Catatonic." Note from the 91G at Bde says he was found in a shell hole after a heavy artillery bombardment, curled up and totally unresponsive. He has received no medication.

Appearance: Shuffles in like a zombie, being led by one hand while the other arm hangs limply. Stares blankly straight ahead, does not speak or react to verbal commands, but passively lets himself be steered, then stands limply until guided by manual pressure to sit down.

History of Present Condition: No further history available. He gives no response to questioning, but sits with shoulders hunched, head slightly bowed, staring blankly at nothing.

Past Medical/Social History: None available.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE A

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

	I	II	III	IV
Return to duty (time _____)	a	a	a	a
Return to Bde trains for rest & replenishment (time _____)	b	b	b	b
Return to unit for administrative action (time _____)	c	c	c	c
Return to Med Clr for evaluation or treatment (time _____)	d	d	d	d
Hold for rest, replenishment and RTD	e	e	e	e
Hold for rest and reevaluation	f	f	f	f
Hold for evacuation ASAP	g	g	g	g
Evacuated (time _____)	h	h	h	h
3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)				
a. Restraints	a	a	a	a
b. Medication (type?)	b	b	b	b
c. Special observation or evaluation? (what?)	c	c	c	c
d. Other (specify what and at what stage)	d	d	d	d
e. What did you tell the soldier? (specify stage I, II, etc)				

FURTHER DEVELOPMENTS

CASE A ("Catatonic")STAGE I ACTION → STAGE II DEVELOPMENT

- a. Not accepted, as is unmanageable.*
- b. Returned after 6 hr as still immobile, too burdensome.*
- c. Not accepted, further evaluation requested.*
- d. No physical findings, returned after 1 hr.*
- e. After 8 hr sleep, answers questions slowly, still in a daze, disoriented to time and place, amnesic for combat, but knows own name, does what told (but slowly), eats well. Still socially withdrawn.
- f. Same as "e."
- g. Same as "e" if not yet evacuated when feedback given "8 hr later."*

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c/d. Same as for Stage I - II.*
- e. After a second long sleep, looks much improved. Moving more normally, showing some affect. Remembers his unit but not combat, is somewhat anxious. Talking with others.
- f/g. Same as "e" under Stage I - II.
- h. If evacuated, no feedback until after exercise, when are told that evacuation led to patient stabilizing at Stage I - II "e."

STAGE III ACTION → STAGE IV DEVELOPMENT

- a/b. Returned with severe anxiety reaction after 12 h.
- c/d. Same as for Stage I - II.
- e. Has remembered most combat experience in group sessions or hypnotherapy. Much improved, still apprehensive but willing to return to unit.
- f/g. Same as "e" under Stage II - III.
- h. Same as for Stage II - IIIh except stabilized at Stage II - IIIe.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

TEACHING POINTS & JUDGEMENT CALLS

CASE A

1. A's catatonic-like blocking out of all stimuli during an intense artillery bombardment is an extreme but effective means of handling intolerable fear when immobility is the only defense. He may have been alone, without social support, in that shell hole. Only the persistence of symptoms is a problem.
2. We cannot totally rule out catatonic schizophrenia, but a working diagnosis of "Transient Battle Reaction (or Battle Fatigue) manifested by brief catatonic reaction under artillery bombardment and persistent muteness and passivity" is justified. He has already improved enough to assist compliantly in his evacuation to safety. It is essential not to further increase secondary gain from "zombie-like" behavior or to foster a belief in serious mental illness.
 - a. Use of medication is a "judgement call". If he can sleep without them, that is best, but moderate doses of valium or a barbiturate would be okay provided he is told they are only to help him relax and rest. Do not use Thorazine unless evidence of schizophrenia presents itself.
 - b. Restraints should not be used, but close observation is indicated for a while; the 91G's should be alerted and perhaps other recovering battle fatigue cases can be assigned as "buddies" to watch over him.
 - c. After sleep, the buddies should make sure A gets himself cleaned up, over to the mess line, etc., all without being waited on and with positive expectation of full recovery.
4. Opportunity to share experiences and ventilate feelings is important. The 91G or other group facilitator can help put A's reaction to stress in perspective (see para 1). As soon as he is ready, he should be involved with others in simple military tasks like improving the position (digging trenches, camouflaging, etc.)
5. The Further Developments show A improving gradually if treated in this fashion, but remaining disabled if too much presumption of illness occurs. Return to his own unit is best, and should not be too difficult since the precipitating stress and his reaction to it were more likely to elicit empathy than rejection. If he can't be returned to his old unit, he should be sent out with buddies gained here.

Note: A's racial origin is irrelevant and should be selected as needed to achieve demographic balance among all cases. Gender must be male unless MOS/unit is changed to a non-combat one.

CASE B

20-year-old black female E-3 truck driver referred to you from Med Clearing for evaluation.

Appearance: Attractive young woman with dirty, torn fatigues who arrives unaccompanied, looks depressed, avoids eye contact and talks in a low voice with obvious embarrassment but also anger.

Chief Complaint: "I was trying to change the flat tire by myself when these six guys came along. I asked them for help and the bastards raped me."

History of Present Complaint: The rape occurred two nights ago. She could not see their name-tags in the dark, but one of them was an E-6. After they were through, they put the spare tire on. She reported it when she got back to her unit, but her CO just said "You have to take your chances in war" and that he did not have any choice but to keep sending the female drivers out alone. She has not slept since, has abdominal pains and cramps, crying spells and is so tense she just feels like screaming. She has not had any means of birth control since deployment. She says she will not go back to duty no matter what you do to her.

Past Medical/Social History: Denies previous abdominal or gynecologic problems. "Engaged;" fiance is in the combat theater and she does not know if he is safe. Drinks "socially," admits to having tried marijuana, but none since deployment. No hard drugs.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE B

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

Return to duty (time _____)

I II III IV

a a a a

Return to Bde trains for rest & replenishment (time _____)

b b b b

Return to unit for administrative action (time _____)

c c c c

Return to Med Clr for evaluation or treatment (time _____)

d d d d

Hold for rest, replenishment and RTD

e e e e

Hold for rest and reevaluation

f f f f

Hold for evacuation ASAP

g g g g

Evacuated (time _____)

h h h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints

a a a a

b. Medication (type?)

b b b b

c. Special observation or evaluation? (what?)

c c c c

d. Other (specify what and at what stage)

d d d d

e. What did you tell the soldier? (specify stage I, II, etc)

FURTHER DEVELOPMENTS

CASE B (Rape Victim)STAGE I ACTION → STAGE II DEVELOPMENT

- a/b. Refuses to go, demands administrative action.*
- c. Taken away; feedback later that she is taking administrative action against CO, still refuses RTD and wants you to document her story.
- d. Returned after 3 hr; some bruises but no permanent GYN injury to support her story; too late for sperm exam, too early for pregnancy test.*
- e/f. Went to sleep protesting she will never RTD, but slept well, looks less anxious but more depressed, still not eating well.
- g. Same as e/f if not evacuated by "8 hr."

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c/d. Same as for Stage I - II.*
- e/f. Sleeping and eating better, has ventilated many feelings to 91G counselor. Does not want to return to unit, says she could drive truck and help out here.
- g. Same as e/f under Stage I - II until evacuated.
- h. Evacuated.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a. Still refuses.*
- b/c. Goes, same feedback as Stage I - IIc.
- d. Same as Stage I - IIId.*
- e/f. Helping on unit, willing to consider reassignment, but not to original unit.
- g. Same as e/f under Stage I - II until evacuated.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

*Note: B's racial origin is irrelevant and should be selected as needed to achieve demographic balance among all cases.

NOT USED

CASE C

21-year-old Mexican male E-4 cook, evacuated in restraints via ground ambulance from the Bde Clearing Station and referred to you for evaluation.

Med Note from 91G at Bde: Patient was brought in from his unit in restraints because of agitation, auditory hallucinations and religious delusions.

Tentative diagnosis "Battle Fatigue R/o Schiz."

Appearance: Well-built young man tightly wrapped in sleeping bag with ropes, wide awake, verbal, not hostile or agitated but trying to get you to understand.

Chief Complaint: "The Blessed Virgin, she came to me and tell me Jesus is coming and we must all get ready. No one believe me!"

History of Present Complaint and Mental Status: He has seen the Virgin Mary and she has talked with him (always when he was alone) three times in the past 48 hours. She told him to tell everyone to take the Last Rites because this is the end of the world, but no one will listen to him and he has not been able to find a chaplain. Yes, he did get upset and angry when his CO would not let him go to find one, but he is sorry and will not do it again. His unit has had some close calls but has not had any casualties yet; however, he had been put on a grave detail burying the dead; that was when the Virgin had first come to him. (His speech is rapid, with Hispanic accent and frequent Spanish words.)

Past Medical/Social History: Denies previous visions or mental problems. Admits to getting drunk on beer and "stoned on marijuana before I come into the Army," but only moderate beer drinking since. Denies hard drugs ever.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE C

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

	I	II	III	IV
Return to duty (time _____)	a	a	a	a
Return to Bde trains for rest & replenishment (time _____)	b	b	b	b
Return to unit for administrative action (time _____)	c	c	c	c
Return to Med Clr for evaluation or treatment (time _____)	d	d	d	d
Hold for rest, replenishment and RTD	e	e	e	e
Hold for rest and reevaluation	f	f	f	f
Hold for evacuation ASAP	g	g	g	g
Evacuated (time _____)	h	h	h	h
3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)				
a. Restraints	a	a	a	a
b. Medication (type?)	b	b	b	b
c. Special observation or evaluation? (what?)	c	c	c	c
d. Other (specify what and at what stage)	d	d	d	d
e. What did you tell the soldier? (specify stage I, II, etc)				

C

FURTHER DEVELOPMENTS

CASE C (Religious Hallucinations/Delusions)

STAGE I ACTION → STAGE II DEVELOPMENT

- a/b/c. Not accepted as too sick to manage.*
- d. Returned after 2 hr, no physical findings.*
- e/f. After 8 sleep, looks better, eating well, but still trying to convince others of his religious visions. No problem if not kept in restraints. Speech coherent, without obvious loose associations or test findings suggesting schizophrenia.
- g. Same as e/f if not evacuated by 8 hr.

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c. Returned after 10 hr, still delusional. Has not been violent, but makes others nervous with constant preaching.*
- d. Same as Stage I - II.*
- e/f. After more sleep, food, is interacting more appropriately with others, is not sure whether the Virgin was real or just in his mind.
- g. Same as e/f in Stage I - II if not evacuated by 8 hr.
- h. If evacuated, no feedback.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a/b/c. No feedback after return to unit.
- d. Same as Stage I - II.*
- e. Ready for RTD.
- f. Same as e/f in Stage II - III.
- g. Same as e/f in Stage I - II if not evacuated by 8 hr.
- h. No feedback.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

TEACHING POINTS & JUDGEMENT CALLS

CASE C

1. C's religious visions, "auditory hallucinations" and "delusions" were precipitated by a severe psychological stress (being put on burial detail). Their occurrence is probably culturally acceptable to his religious upbringing in Mexico, and their contact and his actions in response to them are not hard to understand in context. His current behavior is quite appropriate although he must have been more disruptive and possibly even violent earlier.
2. Paranoid Schizophrenia cannot be totally ruled out, but nothing in A's reported or current behavior suggests it. The working diagnosis should be "Transient Battle Reaction (or Battle Fatigue) manifested by culturally determined religious auditory/visual experiences".
3. C's visions and the actions he is likely to take in response to them are not intrinsically dangerous to himself, others or the mission. They could even improve his effectiveness by calming his anxiety. He is worth risking removing from restraints and reassuring that you know he is not crazy and that such experiences have come to others in battle.
3. Immediate return to duty to his old unit is not wise until the cultural gap can be reduced and his reacceptance into it smoothed. Rest and replenishment with strong positive expectation of RTD provides time for unobtrusive observation (to rule out behavior risks) and facilitation.
4. Try to help A reconcile the conflicting religious and military perspectives more appropriately e.g., it is all right and even helpful to pray for those who can't or won't take the Last Rites, but this must not interfere with others or with duty. Try to find an R.C. chaplain to administer Last Rites and council. Reliable Spanish-speaking "councilors" or "buddies" may also help.
5. When returning him to duty, send along some reassurance and guidance to his unit.
6. If treated as crazy, kept in restraints and/or evacuated, A is likely to insist even more strongly in the universal reality of his religious experience, which will probably continue to be interpreted as crazy by others.

Note: C's national origin must be one in which religious visions are tolerated. The gender is irrelevant and could be revised as needed to achieve demographic balance among all cases.

CASE D

21-year-old black male E-3 tracked vehicle mechanic sent ambulatory by his commander to Med Clearing, who referred him to you for evaluation.

Appearance: Well-developed, moderately anxious young man who appears tired and somewhat bewildered.

Chief Complaint: "I must be going crazy. I'm seeing things that aren't real."

History of Present Complaint: Last night while on perimeter guard, he saw an ice cream wagon ("a white one with red and blue letters on it"). Only his partner in the OP kept him from going out to try to buy some ice cream. "I swear I saw it! It was as real as anything!" His partner told the sergeant, who sent him here. He had not slept for 72 hours because of "nerves," lots of work, air raid warnings and frequent moves. He has seen some dead bodies, but no one he knows has been hit yet. He has never seen things like that ice cream truck except that one time. He slept a little in the truck on the way here. He admits having smoked MJ occasionally before the war, but denies taking any drugs, legal or illegal, since deployment.

Mental Status: Fully oriented; talks coherently and somewhat rapidly due to anxiety, which is appropriate to the situation. No loose associations, delusions, or other cognitive disturbances.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)Stage II:Stage III:Stage IV:

ACTION CHECKLIST

CASE D

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

	I	II	III
Return to duty (time _____)	a	a	a
Return to Bde trains for rest & replenishment (time _____)	b	b	b
Return to unit for administrative action (time _____)	c	c	c
Return to Med Clr for evaluation or treatment (time _____)	d	d	d
Hold for rest, replenishment and RTD	e	e	e
Hold for rest and reevaluation	f	f	f
Hold for evacuation ASAP	g	g	g
Evacuated (time _____)	h	h	h
3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)			
a. Restraints	a	a	a
b. Medication (type?)	b	b	b
c. Special observation or evaluation? (what?)	c	c	c
d. Other (specify what and at what stage)	d	d	d
e. What did you tell the soldier? (specify stage I, II, etc)			

D

FURTHER DEVELOPMENTS

CASE D (Benign Sleep Illusions)

STAGE I ACTION → STAGE II DEVELOPMENT

- a/b. No feedback (successful RTD).
- c. More information requested on grounds for action.*
- d. Returned after 2 hr, no findings.*
- e/f. Sleeps soundly without problems, eats well, responds well to reassurance of normality, ready for RTD.
- g. If not evacuated by 8 hr, sleeps well but still worried about losing his mind.

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b. No feedback (successful RTD).
- c/d. Same as in Stage I - II.*
- e/f. Continues to sleep well, interacts with others, but getting increasingly anxious about possible RTD, beginning to develop psychosomatic symptoms.
- g. If not evacuated by 8 hr, same as e/f and also seeing the ice cream truck again, offering to get people ice cream.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a/b. Returned after 36 hours because "acting strangely." He says that everyone watches everything he does and talk about him behind his back.
- c/d. Same as in Stage I - II.*
- e/f. Same as in Stage II - II e/f and insists he cannot return to duty.
- g. Same as Stage II - III g.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

TEACHING POINTS & JUDGEMENT CALLS

CASE D

1. D's experience of seeing a vivid visual illusion or hallucination after extensive sleep loss is entirely normal and not uncommon. The wishfulfilling content (ice-cream) and lack of immediate insight (had to be kept from going to buy some) are common but not necessary features.
2. Reassurance of normality to A should be put in the strongest terms. A note should also be sent back with him to his unit explaining this to them and giving guidance on providing everyone a minimum amount of sleep (3-4 hours per 24).
3. A should be returned to duty at his unit immediately. Returning him only to his unit's trains for further rest is a poor second. Keeping him in a medical facility even for one night's rest may tend to undermine any reassurance, widen the already opening gulf of confidence between him and his buddies, and increase his anxiety.
4. If the seed of suspicion of mental illness is allowed to germinate, well-fertilized by secondary gain, A is quite likely to become permanently impaired by anxiety and self-doubt. There is even a small possibility that the "innocent" visual illusion can become elaborated and can flower into a "hysterical psychosis".

Note: D's racial origin and gender are not relevant and can be selected/revised as needed to achieve demographic balance among all cases.

CASE E

22-year-old black male E-2 tank gun loader evacuated by supply truck from Bn Aid Station via Bde Clearing Station.

Appearance: Walks in slowly, following escort, sits down on ground, and soon after starts sobbing softly, covering his eyes with his hands.

Field Medical Card: "Battle Fatigue, was returned by unit as unable to rest in Bn field trains. Valium 10 mg prior to evacuation."

Chief Complaint: "They didn't have a chance. Not a chance."

History of Present Complaint: (Told with great effort to control crying): "We'd just started to pull back to our alternate position when we got hit. The tank started to burn, and I bailed out the hatch without waiting for anything. Sarge and Chuck were only halfway out when it flared up. I couldn't go back to help them. I just couldn't. I can't get their screaming out of my mind!" His unit had been in and out of action for the past 6 days, with hard fighting, heavy work refueling and rearming, and maybe 3-4 hours sleep in 24. When they sent him back to the ammunition trucks "after it happened," he felt lost and alone, could not sleep, and "couldn't bear to see the tanks come in to reload."

Past Medical/Social History: Drank beer with the other guys; denies marijuana or drug use. Single, with girlfriend in the States who has not written for three months.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE E

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

Return to duty (time _____)

I II III IV

a a a

Return to Bde trains for rest & replenishment (time _____)

b b b

b b

Return to unit for administrative action (time _____)

c c c

c c

Return to Med Clr for evaluation or treatment (time _____)

d d d

d d

Hold for rest, replenishment and RTD

e e e

e e

Hold for rest and reevaluation

f f f

f f

Hold for evacuation ASAP

g g g

g g

Evacuated (time _____)

h h h

h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints

a a a

a a

b. Medication (type?)

b b b

b b

c. Special observation or evaluation? (what?)

c c c

c c

d. Other (specify what and at what stage)

d d d

d d

e. What did you tell the soldier? (specify stage I, II, etc)

FURTHER DEVELOPMENTS

CASE E (Tanker with Grief and Guilt)STAGE I ACTION → STAGE II DEVELOPMENT

- a/b/c. Not accepted as too difficult to manage.*
- d. Returned after 3 hr, no findings.*
- e/f. Required assistance to sleep, awakened with nightmare but encouraged back to sleep. Not hungry, must be encouraged to eat. Still preoccupied, depressed, occasionally tearful.
- g. If not evacuated by 8 hr, same as e/f.

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c. Still not accepted (returned as unmanageable).*
- d. Same as Stage I - II.*
- e/f. Able to ventilate in group, slept better, eating better, but still depressed.
- g. If not evacuated by 8 hr, same as Stage I - II e/f.
- h. No feedback until end: (depression persisted, took 8 days to return to limited duty.)

STAGE III ACTION → STAGE IV DEVELOPMENT

- a. Returned with severe depression after 24 hr.*
- b. Able to stay with trains on limited duty only.
- c/d. Same as Stage I - II.
- e. Improved, though still anxious about future combat in strange unit.
- f. Same as Stage II - III e/f.
- g. Same as Stage I - II e/f.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

Note: E's racial origin is irrelevant and should be selected as needed to achieve demographic balance among all cases. Gender must be male unless MOS/unit is changed to a non-combat one.

NOT USED

CASE F

22-year-old white male E-3 infantryman sent strapped on a litter by ground ambulance from the Bn Aid Station via Bde Clearing and Medical Clearing.

Appearance: Red-faced young man who alternately struggles against the restraints or lies still, looking anxiously around with a wide-eyed stare, obviously hallucinating. He has no field gear with him.

Chief Complaint: "Get 'em off me! Get 'em off me! For God sake, let me loose! We'll all be burned alive in here!"

Field Medical Card: (From company medic): "Combat Stress Reaction/Schizophrenia." (From Bn Aid Station): "Given 150 mg Thorazine I'm." (From Bde Clearing Co): "Given Thorazine, 150 mg I'm."

History of Present Complaint: Patient appears to know who he is but not that he is in a medical facility. He tries to convince you that the enemy has set fire to the woods with white phosphorus, that there is a wall of flames approaching fast, driving before it rats, snakes and spiders which are crawling in under the tent flaps and running over him. "You can see the glare from the flames, dammit! Can't you smell the f...ing smoke. We'll all be burned to death if you don't let me loose and get us out of here!"

Past Medical/Social History: None available.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE F

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

Return to duty (time _____)

I II III IV

a a a a

Return to Bde trains for rest & replenishment (time _____)

b b b b

Return to unit for administrative action (time _____)

c c c c

Return to Med Clr for evaluation or treatment (time _____)

d d d d

Hold for rest, replenishment and RTD

e e e e

Hold for rest and reevaluation

f f f f

Hold for evacuation ASAP

g g g g

Evacuated (time _____)

h h h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints

a a a a

b. Medication (type?)

b b b b

c. Special observation or evaluation? (what?)

c c c c

d. Other (specify what and at what stage)

d d d d

e. What did you tell the soldier? (specify stage I, II, etc)

FURTHER DEVELOPMENTS

CASE F (Delirious Infantryman)STAGE I ACTION → STAGE II DEVELOPMENT

- a/b/c. Not accepted, as grossly unmanageable.*
- d. Returned after 5 hrs with diagnosis "atropine psychosis." Vital signs stable but patient still psychotic and in restraints. Med Clr is unable to treat symptoms with antidote or to manage in med/surg holding area.*
- e/f. At times, agitated; at others, stuporous. Does get some sleep. (If not kept in restraints, wanders off and causes trouble.) Complains of dry mouth, not being able to urinate, becomes very uncomfortable and anxious. (If given more thorazine, becomes more agitated and develops fever.)
- g. If not evacuated in 6 hr, same as e/f.

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c. Not accepted, as unmanageable.*
- d. Same as Stage I - II plus was catheterized to relieve urinary obstruction.* (If had developed fever due to more thorazine, not returned, but told by Med Clr he has high fever, is being cooled with wet blankets.)
- e/f. Alternately agitated and stuporous, unable to urinate (with high fever if given thorazine). (If Stage I - II = d, improves gradually as in Stage II - IV e/f.)
- g. If not evacuated in 3 hr, same as e/f.
- h. How sedated for transport? If thorazine, hear about severe problems after several hours.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a/b/c. Not accepted, as unmanageable.*
- d. Same as Stage II - III d.*
- e/f. (If no previous "d" action has occurred, medical status is worse); (If a previous "d," improves gradually over 24 hr and can be released from restraints, becomes oriented, admits having taken 3 Atropine syrettes in belief he had been nerve gassed, but does not remember psychotic episode well.)
- g. If not evacuated, same as e/f.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

TEACHING POINTS & JUDGEMENT CALLS

CASE F

1. F is obviously acutely psychotic, and the symptoms strongly suggest some kind of organic toxic or withdrawl state. The hallucinations are primarily visual (nasty vermin, fire) and perhaps also olfactory (smells smoke). His affect is appropriately fearful and agitated for the content of his delusions.
2. While alcohol withdrawl (DT's) or a variety of toxic factors could be involved, several signs suggest Anticholinergic Delirium. This could be due to inappropriate atropine antidote use, exposure to the incapacitant agent BZ, excessive use of anti-histaminic cold medicine, etc. The 300 mg of Thorazine IM F has received also has strong anticholinergic effects and could explain why he is not more sedated.
3. Physical signs to confirm anticholinergic delirium include flushed and red but dry skin (no sweating); very large pupils which do not constrict in reaction to bright light; dry mouth (no saliva); faint, rapid pulse (with risk of shock); elevated temperature (with risk of heat stroke); distended bladder due to urinary retention; level of consciousness which fluctuates between hyperarousal and stupor.
4. If the toxic delirium is not recognized and especially if more Thorazine is given, the Further Developments include worsening of these medical signs into serious complications. While anti-cholinergic delirium can be "cured" quickly with the antidote Physostigmine, this requires careful administration over many hours. In this case, we have assumed that Med Clearing was not able to take this route. Unless the complications prevail, anticholinergic delirium clears in 24-72 hours (depending on cause and severity), and the soldier should be able to RTD after reintegrative activities.
5. Mild cases of Acute Organic Mental Disorders may have to be monitored by the mental health team if the medical staff is overtaxed or less experienced. Evacuation may be legitimate, but may not be available and involves risks unless accompanied by a qualified medic.
6. Restraints should be maintained until the risk of disruptive or self-destructive behavior has cleared. No medication is best, but Valium is acceptable if essential to control severe agitation. Frequent checking of vital signs and mental status should be supplemented with verbal reassurance and information to help reestablish orientation. Once the delirium has cleared, treat like other battle fatigue cases.

Note: F's racial origin is not relevant and should be selected as needed to achieve demographic balance among all cases. Gender must be male unless MOS/unit is changed to a non-combat one.

CASE G

23-year-old white male E-3 brought to Med Clearing by the MPs and referred to you to rule out malingering.

Appearance: Dirty, unshaven, obviously tired and otherwise normal-looking soldier, who seems rather unconcerned at being escorted by an MP. His fatigue jacket name-tag and dog-tags identify him as "Schultz (James E.)."

Chief Complaint: "I don't know what this is all about. I was just walking back to my unit after going to the latrine when these guys picked me up."

History of Present Complaint: The MP explains Schultz was apprehended walking down a road in the division rear far from any unit, gave his name as "Roger Cagney" and said he belonged to a unit that is not part of the division. He still insists his name is Cagney, and cannot imagine how he came to be wearing someone else's dog-tags and jacket. Asked about his past, he says he was born in Milwaukee and has two sisters and a brother but "can't remember" much else and seems mildly puzzled that he cannot.

Past Medical/Social History: Not able to remember any illnesses. Says he drinks "a little;" denies drug or marijuana use.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE G

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

Return to duty (time _____)

I II III IV

a a a a

Return to Bde trains for rest & replenishment (time _____)

b b b b

Return to unit for administrative action (time _____)

c c c c

Return to Med Clr for evaluation or treatment (time _____)

d d d d

Hold for rest, replenishment and RTD

e e e e

Hold for rest and reevaluation

f f f f

Hold for evacuation ASAP

g g g g

Evacuated (time _____)

h h h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints

a a a a

b. Medication (type?)

b b b b

c. Special observation or evaluation? (what?)

c c c c

d. Other (specify what and at what stage)

d d d d

e. What did you tell the soldier? (specify stage I, II, etc)

FURTHER DEVELOPMENTS

CASE G (Fugue State)STAGE I ACTION → STAGE II DEVELOPMENT

- a/b. Not acceptable to MPs.*
- c. Taken away for punishment as deserter.
- d. Return after 2 hr, no medical findings.*
- e/f. Slept well without sedation, ate well, seems cooperative but still no memory or insight.
- g. If not evacuated by 8 hr, same as e/f.

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c/d. Same as Stage I - II.*
- e/f. Continuing to sleep and eat well. Quiet in group ventilation but showing more affect, (anxiety and depression), still amnesic.
- g. If not evacuated by 8 hr, same as e/f.
- h. No feedback.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a/b/c/d. Same as Stage I - II.*
- e/f. With hypnosis or supportive psychiatric drugs, remembers Schultz identity and some of battle stresses. Anxious about RTD for fear it will happen again, but accepts reassurance.
- g. If not evacuated, same as Stage II - III e/f.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

Note: G's racial origin is irrelevant and should be selected as needed to achieve demographic balance among all cases. Gender must be male unless MOS/unit is changed to a non-combat one.

NOT USED

CASE H

24-year-old Hispanic female E-4 91G who has been sent back from one of the brigade clearing stations.

Appearance: 5'1", 95 lb woman who you remember as having been efficient and vivacious in garrison, but who now looks exhausted and depressed. She avoids eye contact as she reports to you and hands you a sealed note from the Bde 91G NCO.

Note from 91G NCO: "SP4 V _____ is no longer able to function this far forward. She has been unable to sleep, has frequent crying spells, and is useless here. Can you send someone else?"

Chief Complaint: (Spoken in a very soft, slow voice, sitting with head in hands): "Sergeant J _____ says I have...have battle fatigue."

History of Present Complaint: The brigade clearing station has been constantly busy since the first hours of the war. In addition to the psychiatric patients, she had to help out with the badly wounded. They have had several near misses from artillery and air, and had to move once or twice a day (or night). She had not been to the field since basic training and did not know what to do, setting up and tearing down the tent, lifting stretchers and gear, watching patients die. "The Army wasn't supposed to...to put me in combat. What am I supposed to do? Please...please let me go home."

Past Medical/Social History: No previous problems. Single. "Moderate drinker" (beer, wine, and cocktails), none since deployment. Denies drug or marijuana use.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE H

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

I II III IV

Return to duty (time _____) a a a a

Return to Bde trains for rest & replenishment (time _____) b b b b

Return to unit for administrative action (time _____) c c c c

Return to Med Clr for evaluation or treatment (time _____) d d d d

Hold for rest, replenishment and RTD e e e e

Hold for rest and reevaluation f f f f

Hold for evacuation ASAP g g g g

Evacuated (time _____) h h h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints a a a a

b. Medication (type?) b b b b

c. Special observation or evaluation? (what?) c c c c

d. Other (specify what and at what stage) d d d d

e. What did you tell the soldier? (specify stage I, II, etc)

H

FURTHER DEVELOPMENTS

CASE H (91G with Anxiety, Depression)

STAGE I ACTION → STAGE II DEVELOPMENT

- a/b/c. Goes passively but is returned after 6 hr, more depressed, shaking and crying uncontrollably.*
- d. Returned after 2 hr, medically cleared.*
- e/f. Sleeps without sedation, eats only a little, still looks depressed but not tearful. (If instructions were to assign her simple 91G tasks, she does them.)
- g. If not evacuated by 8 hr, same as e/f except still occasional crying.

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c. (If Stage I - II = e/f) same as Stage I - II a/b/c except returned after 24 hr.*
- d. Returned after 2 hr, medically cleared.*
- e/f. Sleeping well, eating better, interacting better with staff and other cases: beginning to take initiative in performing 91G role.
- g. If not evacuated by 24 hr, same as Stage I - II e/f.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a. RTD, doing OK as long as protected.
- b/c. Rested OK but feels isolated, requests return to Mental Health Team.
- d. Medically cleared.*
- e/f. Continues to work well as MH team member.
- g. If still not evacuated, same as Stage I - II e/f.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

Note: H's racial origin and gender are not relevant and can be selected/revised as needed to achieve demographic balance among all cases.

NOT USED

CASE I

25-year-old white male E-3 radio operator evacuated to you from Bde Clearing in restraints by ground ambulance.

Appearance: Young male strapped on stretcher who looks apprehensive and tense, eyes shifting suspiciously all around the tent.

Medical Note from 91G at Bde: "Rule out paranoid schizophrenia. SM was brought in restraints from his unit with a note that he had started to act withdrawn and strange from the first day of deployment (was always somewhat a loner), was heard talking to himself, and finally told his CO that the President was talking to him directly and that everyone should obey his orders." He received 150 mg of Thorazine prior to evacuation.

Chief Complaint: "You know" (said with a subtle, superior smile).

History of Present Complaint and Mental Status: After some verbal fencing in which the patient insists you already know because you are in on it, he reveals that he has "ESP," has been hearing and understanding the Russian radio messages in his head and knows what they are going to do next, and has communicated this mentally to the President. You and his commander are KGB agents but will not be able to stop him from using his mind. His thinking is concrete, with occasional odd use of words.

Past Medical/Social History: None available.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE I

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

	I	II	III	IV
Return to duty (time _____)	a	a	a	e
Return to Bde trains for rest & replenishment (time _____)	b	b	b	b
Return to unit for administrative action (time _____)	c	c	c	c
Return to Med Clr for evaluation or treatment (time _____)	d	d	d	c
Hold for rest, replenishment and RTD	e	e	e	e
Hold for rest and reevaluation	f	f	f	f
Hold for evacuation ASAP	g	g	g	g
Evacuated (time _____)	h	h	h	h
3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)				
a. Restraints	a	a	a	a
b. Medication (type?)	b	b	b	b
c. Special observation or evaluation? (what?)	c	c	c	c
d. Other (specify what and at what stage)	d	d	d	d
e. What did you tell the soldier? (specify stage I, II, etc)				

I

FURTHER DEVELOPMENTS

CASE I (Paranoid Schizophrenic)

STAGE I ACTION → STAGE II DEVELOPMENT

- a/b. Not accepted, as is unmanageable.*
- c. MPs return in two hours and report he was shot attempting escape.
- d. Returned after 4 hr, no evidence of organic factors.*
- e/f. (If kept in restraints, with or without sedation: slept OK, still suspicious, withdrawn, with shifting gaze and sly smile; little communication, but apparently still hallucinating, with loose associations.) (If psychological - tested: is uncooperative, but his few responses suggest schizophrenic processes.) (If not kept restrained: cannot be found, having slipped away at night. Consider yourself lucky he did not kill someone on his way out.) (If heavily thorazined: same as above but blander, sleeps more.)
- g. If not evacuated by 8 hr, same.

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c/d. Same as Stage I - II.*
- e/f. Same as Stage I - II e/f. No improvement.
- g. Same as Stage I - II e/f.
- h. Evacuated (restraints required,* sedation preferred). If not in restraints, is returned after 1/2 hr, having attempted unsuccessfully to grab an M16 from the ambulance during loading.

STAGE III ACTION → STAGE IV DEVELOPMENT

All same as for Stage II - III.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

TEACHING POINTS & JUDGEMENT CALLS

CASE I

1. I's history and current behavior are all characteristic of a paranoid schizopreniform psychotic episode. He is having purely auditory hallucinations which he has organized into a delusional system based on pseudo-scientific, irrational logic, with himself occupying a grandiose role. He is attempting to act on his delusion, and has incorporated those who oppose him (including you - entirely without basis, we trust) into the delusion as enemy spies.
2. I is obviously a clear and present danger who must be kept in restraints, under observation, and preferably heavily medicated with an anti-psychotic such as Thorazine. (Note that a 150 mg dose of Thorazine which would knock most people out hasn't phased him yet).
3. We need not be concerned with whether A's illness represents an acute, transitory stress reaction or a first episode of underlying schizophrenia. The content of his delusions and the actions they may direct him to take are too dangerous in an uncontrollable setting where deadly weapons are readily available. He should be evacuated ASAP, still in restraints and as sedated as is feasible.

Note: I's racial origin and gender are irrelevant and should be selected/revised to achieve demographic balance among all cases.

CASE J

26-year-old white male E-4 infantryman evacuated by ground ambulance from the company aidman via Bn Aid Station and Bde Clearing Station and sent to you from Med Clearing.

Appearance: Tall, thin, worried-looking man in field gear but without helmet, who walks under escort.

Field Medical Card: "Transient Battle Reaction, Panic Run" to which the PA at Bn has added "Disoriented to time, place and person" and the 91G at Bde has added "Still disoriented to time, knows person and place, can't remember battle." No medications.

Chief Complaint: "Sir, I don't know what happened. I can't remember."

History of Present Condition: (Told in worried voice but without physical signs of anxiety or difficulty with speech): Now oriented to time. Knows his unit designation and remembers their deployment forward and being strafed by jet fighters on the road; he thinks that was several days ago and that only a few people were hurt. He thinks he remembers digging in with his squad at a tree line overlooking a village. "Something awful must have happened, Sir. I can't remember anything else. Do you think they're all dead and I'm the only one left?" (Afraid to go back to his unit for fear his friends are all dead.)

Past Medical/Social History: Married, no children; wife is in combat theater and he does not know if she is safe. No prior blackouts or memory loss. Moderate drinker (believes none since deployment), denies drug or marijuana use.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE J

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

I II III IV

Return to duty (time _____)

a a a a

Return to Bde trains for rest & replenishment (time _____)

b b b b

Return to unit for administrative action (time _____)

c c c c

Return to Med Clr for evaluation or treatment (time _____)

d d d d

Hold for rest, replenishment and RTD

e e e e

Hold for rest and reevaluation

f f f f

Hold for evacuation ASAP

g g g g

Evacuated (time _____)

h h h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints

a a a a

b. Medication (type?)

b b b b

c. Special observation or evaluation? (what?)

c c c c

d. Other (specify what and at what stage)

d d d d

e. What did you tell the soldier? (specify stage I, II, etc)

FURTHER DEVELOPMENTS

CASE J (Panic/Amnesia)STAGE I ACTION → STAGE II DEVELOPMENT

- a/b. Returned after 12 hr as increasingly depressed and anxious, unable to function.*
- c. Placed in punishment detail?
- d. Returned after 2 hr, no medical findings.*
- e/f. Sleeps adequately without sedation, eats well, cooperative, participates in group ventilation, remembers more but still not the panic run. Still worries about buddies, afraid to find out what happened.
- g. If not evacuated, same as e/f.*

STAGE II ACTION → STAGE III DEVELOPMENT

- a. Not possible (unit isolated), same as Stage I - II a/b.
- b. Able to rest OK but still anxious, becoming depressed. Returned after 24 hr.*
- c. Same as Stage I - II?
- e. (If Stage I - II = e/f) continues to improve with group ventilation (hypnosis?), remembers panicking during air attack, being tackled by buddies. Knows some were killed, afraid he will crack again if he goes back.
- f. Same as Stage I - II e/f.
- g. Same as Stage I - II e/f, except more depressed.
- h. No feedback.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a/b. (If Stage II - III = e/f) successful RTD.
- c/d. Same as Stage I - II.
- e. Continues to improve, feels ready for RTD.
- f. Same as Stage II - III f.
- g. If not yet evacuated, same as Stage I - II e/f.
- h. No feedback.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

*Note: 's racial origin is irrelevant and should be selected as needed to achieve demographic balance among all cases.

NOT USED

CASE K

27-year-old white female E-5 Hawk missile crewman sent over from Med Clearing for evaluation.

Appearance: Dishevelled, covered with dirt and some dried blood, red-eyed, shaking, trying to keep from crying.

Chief Complaint: (Spoken in a depressed, defeated tone of voice): "I thought I could take it, but I guess I can't."

History of Present Condition: (Voice becomes more animated, ready to talk.) Was in charge of two females (E-3 & 4) and one E-4 male in the radar section of a Hawk missile battery which has been in action for three days. Several hours ago the radar van was hit by rockets from a Soviet Hind. She was not in it, but when she got to it she found her three technicians "in pieces all over the place." "I went all to pieces, too, and my battery commander relieved me and sent me over to the medics." Feels she let her unit down, disgraced herself and lacks the courage to face all that blood and death. Thinks the CO does not want her back.

Past Medical/Social History: No prior medical or mental problems. Single. Drinks occasional beer or cocktail, none since deployment. Denies drug or marijuana use.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

K

FURTHER DEVELOPMENTS

CASE K (Anxious/Depressed Hawk Missile Crewperson)

STAGE I ACTION → STAGE II DEVELOPMENT

- a. No feedback (OK if given good reassurance and expectation). (Note to CO?)
- b. No feedback (successful RTD) if given good expectation.
- c. More information requested on grounds for admin action.*
- d. Return after 1 hr, no medical findings.*
- e/f. Asks for mild sedation to sleep but slept well, not hungry.
- g. If not evacuated by 6 hr, slept with sedation but awoke depressed, tearful.*

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b. No feedback (successful RTD).
- c/d. Same as Stage I - II.*
- e. Initially hesitant in groups but ventilated to 91G, responded well to reassurance of normality, wants to RTD.
- f. Same as e except still self-doubting, afraid to RTD, asks for sedation to sleep.
- g. If not evacuated by 24 hr, continues depressed, anxious, cannot sleep without sedation.
- h. No feedback until re-cap (has not recovered enough to RTD).

STAGE III ACTION → STAGE IV DEVELOPMENT

- a/b. No feedback (OK).
- c/d. Same as Stage I - II.*
- e. Slept OK without sedation but beginning to look depressed and anxious again.
- f/g/h. Same as Stage II - III f/g/h.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

Note: K's racial origin and gender are irrelevant and should be selected/revised to achieve demographic balance among all cases.

NOT USED

CASE L

28-year-old white male E-5 section chief on a 155 mm howitzer who came to Med Clearing escorting a wounded man, asked for something to calm his nerves and was sent to you for evaluation.

Appearance: Enters unescorted, with slow, shuffling gait; wide-eyed, distant stare; sagging facial expression, unkempt and unshaven. Speech slowed, with depressed, self-deprecating tone. Sits passively staring down, no eye contact.

Chief Complaint: "My nerves are shot. I can't take it anymore."

History of Present Complaint: Feels he cannot do his job because he jumps at the slightest sound. cannot remember orders or the new men's names, keeps mixing up the digits when he sets the firing data, forgets what he is trying to do, feels in a daze. He has not slept for three days because every time he falls asleep he dreams of dead bodies and explosions and wakes up terrified. His battery has been in continuous action for 6 days and has lost almost half its personnel to enemy fire. His own howitzer has lost several men and has a couple replacements; the vehicle itself is being repaired now, but he has got to get back. "Isn't there something you can give me for my nerves?"

Past Medical/Social History: Married; wife and two children are in the combat theater and he does not know if they are safe. He usually drank about two six packs of beer per week, none since deployment. Denies drug or marijuana use.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE L

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

I II III IV

Return to duty (time _____)

a a a a

Return to Bde trains for rest & replenishment (time _____)

b b b b

Return to unit for administrative action (time _____)

c c c c

Return to Med Clr for evaluation or treatment (time _____)

d d d c

Hold for rest, replenishment and RTD

e e e e

Hold for rest and reevaluation

f f f f

Hold for evacuation ASAP

g g g g

Evacuated (time _____)

h h h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints

a a a a

b. Medication (type?)

b b b b

c. Special observation or evaluation? (what?)

c c c c

d. Other (specify what and at what stage)

d d d a

e. What did you tell the soldier? (specify stage I, II, etc)

FURTHER DEVELOPMENTS

CASE L (Artillery NCO with "Classic" Battle Fatigue)

STAGE I ACTION → STAGE II DEVELOPMENT

- a. No feedback (good RTD) if strong instructions to get sleep, respite.
- b. No feedback (good RTD).
- c. More information requested on action recommended.*
- d. Returns in 2 hr; dx "normal" stress reactions.*
- e. Slept (with or without sedation) though awakened by bad dreams. Eating OK, still somewhat tremulous but looks less depressed, wants to RTD.
- f. Same as e but does not push for RTD.
- g. If not evacuated by 8 hr, needed sedation to sleep, still anxious, tremulous, looks more depressed.

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b. No feedback (good RTD) if Stage I - II = d/e/f.
- c/d. Same as Stage I - II.*
- e. Same as Stage I - II.
- f. Sleeping and eating OK, is cooperative but passive, does not participate in groups or ventilate; more depressed.
- g. Same as f.

STAGE II ACTION → STAGE IV DEVELOPMENT

- a/b. Same as Stage II - III.
- c/d. Same as Stage I - II.*
- e. Same as Stage I - II r.
- f/g. Same as Stage II - III f.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

TEACHING POINTS & JUDGEMENT CALLS

CASE L

1. L shows a typical cluster of severe, but not totally disabling, stress-reactions for a responsible leader or NCO who has been in prolonged danger with physical fatigue and sleep loss. The problem is to insure he gets sleep and other replenishment without undermining his strong sense of responsibility and duty. His insomnia and battle dreams may also interfere with his getting rest.
2. Reassurance, education about combat stress, and immediate return to his unit with a strongly-worded prescription for sleep (there or in the logistical trains) is probably best. If you have serious doubts that he can sleep there, he could be kept at the MTF for some clearly-stated brief period and purpose; e.g., "I know that a highly-motivated NCO like you will feel too responsible to let yourself sleep there, and you must get that sleep, so I'm going to keep you here for 6 hours and insure that you get it". The risk of this is increased psychological distance from the unit (who are probably no better off than he is); it may also become physically difficult to get him back to them.
3. L asks for something to help him calm his nerves, function more effectively and get sleep. Reassurance that what he has is normal and will improve (although not completely) with sleep may help somewhat. His short-term memory and attention problems can be helped by taking written notes and by stressing team double-check procedures (which also helps share responsibility and rebuild team cohesion). Advice on relaxation techniques might be useful in the long run, but he may be too "shot" to use them now.
4. What L wants is medication, but it must not be something which could interfere with his dangerous job. Valium (5 mg or even 2.5 mg) or even placebo could be given in small quantity, with instructions to take only one (or 1/2) only when he is sure he can get at least 4 hours uninterrupted sleep. Strong suggestion that he will be able to sleep when he doesn't feel that it is his duty to stay awake may help, and that the bad dreams are a normal working through of daytime experiences which mustn't be allowed to keep him from sleeping.
5. A note should be sent back with him to his unit documenting your "prescriptions" and stressing the need for sleep for all personnel.

Note: L's racial origin is irrelevant and should be selected as needed to achieve demographic balance among all cases. Gender must be male unless MOS/unit is changed to a non-combat one.

CASE M

38-year-old black male O-3 commander of an engineer company referred to you from Med Clearing for evaluation.

Appearance: 6'1", 250 lb black male who walks in unescorted; very tense, arms clenched across his chest as he tries to control his shaking.

Chief Complaint: "Doc, I can't get...ahold of myself...I keep shaking... I can't do anything, I can't even think straight."

History of Present Complaint: (Spoken haltingly, with long pauses to think, while still shaking): His company was pulled back for rest and reconstitution after losing "over 60 men;" they were briefly in action with enemy tanks and only some got away. "I was alright then. Honest I was, Sir." But his company kept getting harassed by artillery and air attack and had to keep moving all the time, and more men were hurt; he could not get the maintenance people to fix anything and his CO kept wanting to know when his unit was going to be ready again. "I just broke down crying...in front of the CO. And...and...well...he told me to get my ass over here and get myself straightened out."

Past Medical/Social History: Married with three children in the States; is on unaccompanied tour. "Moderate drinker" ("a scotch or two at the Club after work"). Denies drug or marijuana use. Only persistent questioning uncovers that those were big scotches, sometimes in the morning, too. He has been cutting back and still has one and a half bottles left of the supply he brought to war.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE M

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

I II III IV

Return to duty (time _____)

a a a a

Return to Bde trains for rest & replenishment (time _____)

b b b b

Return to unit for administrative action (time _____)

c c c c

Return to Med Clr for evaluation or treatment (time _____)

d d d d

Hold for rest, replenishment and RTD

e e e e

Hold for rest and reevaluation

f f f f

Hold for evacuation ASAP

g g g g

Evacuated (time _____)

h h h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints

a a a a

b. Medication (type?)

b b b b

c. Special observation or evaluation? (what?)

c c c c

d. Other (specify what and at what stage)

d d d d

e. What did you tell the soldier? (specify stage I, II, etc)

FURTHER DEVELOPMENTS

CASE M (Engineer Commander with Shaking, Depression)STAGE I ACTION → STAGE II DEVELOPMENT

- a/b. Leaves reluctantly; returns after 6 hr, drunk, with strongly-worded note from CO about getting alcoholics off the battlefield. (If CO was contacted before attempted RTD, get same strong message.)*
- c. Additional grounds for admin action required.*
- d. Returned after 2 hr; suspect but cannot confirm alcohol withdrawal, suggest prescribing Librium.*
- e/f. If prescribed Librium or Valium, sleeps well, shaking somewhat less. (If no medications prescribed, asks for medicine to sleep, to calm nerves, given Valium and slept OK but still depressed and shaky on awakening.)
- g. If not evacuated by 8 hr, same as e/f; still shaking.

STAGE II ACTION → STAGE III DEVELOPMENT

- a. Same as Stage I - II a.*
- b. (If given Librium or Valium to take along, no feedback.) (If no medication provided, same as Stage I - II a.)
- c. Additional grounds required.*
- d. Same as Stage I - II d.*
- e. If on Librium or Valium, continues to improve if given some responsibility; does not interact with 91Gs or ventilate with enlisted cases. (If no medications provided, same as Stage I - II e/f without medications.)
- f. Same as e, but more depressed, still shaky.
- g. If not evacuated yet, is becoming more depressed, tearful, passive.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a/b. If has been on medications, same as Stage II - III b. (If no medications provided, same as Stage I - II a.)
- c. Taken away for admin action; no feedback until end of exercise.
- d. Return after 1 hr, condition OK; can taper off medications if any being given.
- e. If on medications, rests well, shaking and other symptoms improved, medications being tapered, asks when can RTD. (If no medications provided, rests well, shaking has improved, still depressed, quiet.)

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

CASE M (Contin.)

- f. Same as Stage II - III f.
- g. Same as Stage II - III g; wishes he had died in battle.

TEACHING POINTS & JUDGEMENT CALLS

CASE M

1. M's symptoms of depression, difficulty coping, crying easily and gross shaking could be accounted for by battle fatigue from the intense combat he has been in, compounded perhaps by frustration and the effort to maintain self control. If M is quoting his CO accurately, it would not be surprising if he was wrestling with internal rage. You should be concerned with whether the CO may also be suffering from stress, and perhaps contact nearby medical personnel to get more information.
2. However, it is also possible that M isn't telling everything and that the CO may have had justifiable grounds for relieving him and sending him to the medics/mental health team to get "straightened out". The symptoms of minor alcohol withdrawal are indistinguishable from battle fatigue (anxiety, irritability, insomnia with bad dreams, fine tremor, GI and autonomic nervous system disturbances), and the two causes are not mutually exclusive. Total abstinence is not necessary to get withdrawal symptoms -- just an abrupt drop in habitual alcohol intake. Gross shakiness could be a warning sign of impending Delirium Tremens (gross tremor is the "T" in DT's).
3. There is no field lab or diagnostic test to assess the risk of DT's, and M is apparently not welcome back to his old job right away, so it would not be wise to send him back without at least observing and resting him for awhile. Confirming the diagnosis is less important than minimizing problems and returning M to duty ASAP. Therefore, consider immediate medication with Librium (50 mg p.o.) or if that is not available, with Valium (10 mg p.o. or I.M) Vitamin B complex may also be advisable.
4. It is more essential than ever to maintain positive expectation of return to honorable duty. The possibility of alcohol withdrawal needs to be discussed frankly with M but it can be said that the treatment of two to three days of sleep, rest, good nutrition and hygiene, and a brief course of Librium or Valium rapidly tapering to zero is appropriate even if alcohol isn't a factor.
5. Your associates and staff should be briefed, including the possibility of DT's, epileptic seizures and a small risk of suicidal behavior. M should be involved as soon as possible in light duties "appropriate to his rank", e.g. team leader for some "engineering" construction. Involvement in group should give him opportunity to ventilate the combat stress he and his company endured, but not force him to lose face over his subsequently being relieved.
6. Contact with M's command chain should be made to smooth his return to useful duty.

Note: M's racial origin is irrelevant and should be revised as needed to achieve demographic balance with other cases. Gender must be male unless MOS/unit is changed to a less front-line combat-support one or rank is reduced so that "she" can be a recent West Point graduate.

CASE N

24-year-old married E-4 battalion clerk-turned-infantryman, evacuated by ground ambulance from a BAS by way of _____ Bde Clearing Station.

Appearance: Young white male, asleep on stretcher.

Field Medical Card: "Combat Stress Reaction manifested by weakness of arms and legs (he believes due to nerve gas, but no exposure proven)." No improvement after 12 hours rest at Bde Trains. No medications given since atropine 4 mg buddy aid.

Chief Complaint: "I can hardly move. It's so hard to lift my feet. My hands are so weak. I can't even hold my rifle."

History of Present Complaint: (Continues to speak slowly and softly, but with no problems finding words): "I was doing OK as clerk in the battalion supply section, although our platoon had three wounded by artillery in 3 days. Then me and two others got picked to go forward as replacements to Charlie Company. We got there in the evening. Charlie Company was supposed to be in reserve after getting chewed up bad, but we'd only been there a couple hours when we got rocketted with smoke that had some kind of gas in it. I was slow getting my mask on - I know it was my fault - and I didn't have any MOPP suit. Then the shooting started over on the right, but when they told us to get over there, I couldn't move my arms or legs or nothing, and I could hardly breathe. My buddy gave me two atropines and that kept me breathing. I think he saved my life. But the aidman wouldn't give me no more; said I hadn't been gassed at all. All I know is I've never had any trouble like this before, and now I'm so weak I can't even lift my hand. They told me at the Clearing Station that I'd be better after some sleep, but I'm just as bad off."

Past History: Denies previous weakness, illness or other neurological symptoms. Admits to occasional marijuana smoking but denies other drug use.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE N

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

I II III IV

Return to duty (time _____) a a a a

Return to Bde trains for rest & replenishment (time _____) b b b b

Return to unit for administrative action (time _____) c c c c

Return to Med Clr for evaluation or treatment (time _____) d d d d

Hold for rest, replenishment and RTD e e e e

Hold for rest and reevaluation f f f f

Hold for evacuation ASAP g g g g

Evacuated (time _____) h h h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints a a a a

b. Medication (type?) b b b b

c. Special observation or evaluation? (what?) c c c c

d. Other (specify what and at what stage) d d d d

e. What did you tell the soldier? (specify stage I, II, etc)

FURTHER DEVELOPMENTS

CASE N (Weakness Attributed to Nerve Gas)

STAGE I ACTION → STAGE II DEVELOPMENT

- a/b. Refused as not ambulatory.*
- c. Refused as not yet documentable grounds.*
- d. Examination and available lab tests show no evidence for nerve gas or other physical basis.*
- e/f. Slept well without medication. Insisting he is too weak to get up from cot to go for food, shower or group ventilation.
- g. Evacuation deferred by Division Psychiatrist, condition same as f (above).

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c/d. Same as Stage I - II.*
- e. Still insisting he is weak, but was able to crawl slowly to the latrine and walked back very slowly via chow line.
- f. Still holding out in cot as too weak to walk. Counselled against urinating next to cot. Says he cannot sleep because he is too hungry.
- g. Evacuation deferred, condition same as Stage II - III f.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a. Still refused as not ambulatory.*
- b. Returned after 6 hr as unacceptable burden who refuses to care for self; ambulatory.*
- c. Taken away for punishment.
- d. Still no physical findings.*
- e. Slowly "getting stronger" and participating in group activities.
- f. Same as Stage II - III e.
- g. Still deferred by Division Psychiatrist, condition same as Stage II - III f (unless essential to move him out because of space crunch, in which case action "b." Preferred as temporary expedient).

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

Note: N's racial origin and gender are irrelevant and would be selected/revised to achieve demographic balance among all cases.

NOT USED

CASE 0

23-year-old O-2 tank platoon leader evacuated from Bn Aid Station by ground ambulance and referred to you from Med Clearing.

Appearance: Young-looking white male officer in tanker's uniform, led in ambulatory by the hand, who fails to duck his head under the canvas door flap even though eyes are open and staring forward. He has to be helped to find a seat and sits staring blankly ahead.

Field Medical Card and Note: Aidman: "Blind in both eyes, laser." Bn Aid Sta: "PERRL, no reaction to accommodation but claims he can't see anything and doesn't follow finger with eyes. Retinas appear normal. R/O conversion reaction. Irrigated eyes with saline, bandaged." Med Clearing Co: "Condition unchanged. No evidence of retinal burns. Bandages removed."

Chief Complaint: (Spoken with embarrassment and worry, but not severe anxiety): "The doctors say there's nothing wrong with my eyes, but I can't see anything. It's dark as night. I swear to God, I'm not faking this!"

History of Present Complaint: (In same worried, embarrassed tone, but no evident agitation about being blind): "I was studying our objective through my binoculars (it was a low hill with enemy tanks and mech infantry digging in on it) and things began to get foggy. At first I thought they were using smoke to cover themselves, but it got thicker and darker, even when I stopped looking, and in a couple minutes everything was black! No, it never did hurt, it just happened slowly. If it wasn't a laser they shined at me, maybe they have some other kind of microwave weapon that blinds people without showing in the eyes?" His unit flew over from the States as one of the first Reforger reinforcements; got their tanks out of POMCUS, got caught in traffic jams, were strafed once but not badly, and only last night got into action. "My platoon was in overwatch when 2d platoon got hit on that hill. We covered their withdrawal, then got orders to counterattack. It's not fair, my getting blinded before I could even fight. My best friend from Armor School was leading 2d platoon; his tank made it back to us OK, but he'd been hit by a machine gun bullet...went in one eye and out the other. It was a real mess...I don't know why he wasn't screaming, but he was taking it real well."

Past Medical History: Never any neurological or visual problems. Has never used drugs, does not smoke or drink (he is Mormon, and even feels a little bad about drinking coffee, but has to to keep awake).

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

RD-A149 034

PROCEEDINGS: SECOND USER'S WORKSHOP ON COMBAT STRESS
HELD AT FORT SAM HOU. (U) ACADEMY OF HEALTH SCIENCES
(ARMY) FORT SAM HOUSTON TX HEALTH C.

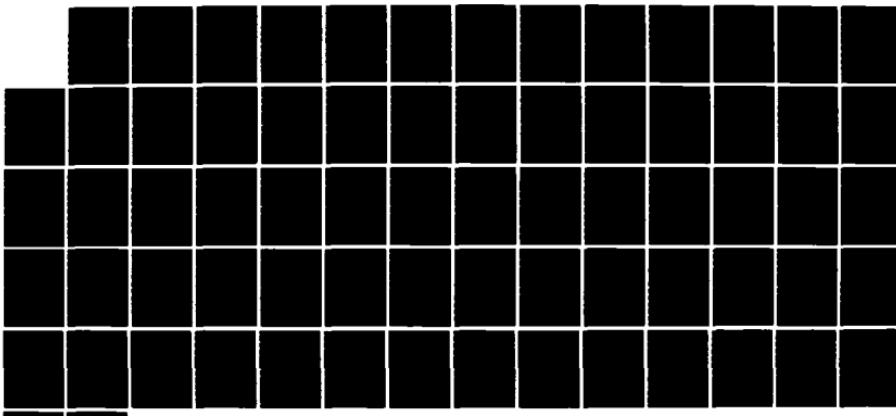
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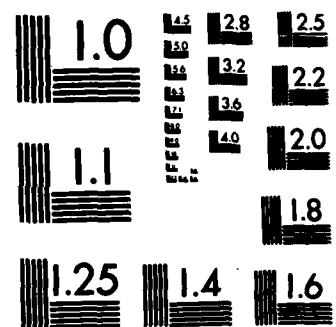
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MICROCOPY RESOLUTION TEST CHART
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FURTHER DEVELOPMENTS

CASE 0 (Armor Officer with "Laser Blindness")

STAGE I ACTION → STAGE II DEVELOPMENT

- a. Not accepted as cannot be managed.*
- b. Returned after 24 hr as not improved.*
- c. Division Psychiatrist defers this, pending treatment trial.*
- d. Exam confirms still no evidence of retinal injury. Pupil response to light indicates significant degree of optical nerve function is intact bilaterally.*
- e/f. Slept adequately without medication. Says the blackness is now a lighter grey and he can see very vague shapes close up. Controlled irritation about not being given food or being led to latrine, insists he cannot see well enough to follow someone.
- g. Evacuation deferred by Division Psychiatrist. Slept well without medication. No improvement in vision, and otherwise same as "f."

STAGE II ACTION → STAGE III DEVELOPMENT

- a. Not accepted by unit as cannot be managed.*
- b. Returned after 18 hr, unimproved, as burden to unit.*
- c. Requirement to substantiate charges.*
- d. Same as Stage I - II d.*
- e. Some participation in group; followed others to chow. Given hypnotic suggestion before sleep; slept well and is able to see much more clearly today though still reports colors are faded.
- f. Same as e, above, except vision still very fuzzy as well as colorless.
- g. Evacuation still deferred by Division Psychiatrist. If census must be reduced, take action "b." Condition now same as Stage I - II f.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a. Still not accepted.*
- b. Continued to improve slowly, remains with trains, but capable of only limited duty.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

CASE 0 (Contin.)

- c. Same as Stage II - III c.*
- d. Same as Stage I - II d.*
- e. Much improved, is grateful and talks about return to his unit.
- f. Same as Stage II - III e.
- g. Same as Stage II - III g except condition same as Stage II - III t.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

Note: O's racial origin is not relevant and should be selected as needed to achieve demographic balance among all cases. Gender must be male

CASE P

24-year-old E-3 cavalry scout (driver) sent to you from the med/surg holding section of the Med Spt Co.

Appearance: Young, anxious-looking white male who walks in slowly with a very prominent limp, wincing with each step.

Medical Note: He was admitted 36 hours ago for cleaning of shallow wounds of the right gluteus maximum (buttock) and right gastrocnemius (calf) muscles caused by low velocity missile fragments. The wounds have been dressed, there was no damage to nerves or blood vessels and he is judged ready for return to limited duty at his battalion. However, he continues to complain of more severe pain than the wound explains, and insists he can hardly walk.

Chief Complaint: (He begins talking in a low, flat, puzzled voice): "The doctor says my wounds are healing OK and that I have to expect them to hurt for a while, but...it hurts so much I can hardly stand it, and they won't give me no pain medicine. Just aspirin."

History of Present Complaint: (He becomes increasingly anxious as he talks.) His armored cavalry troop was heavily involved in delaying the enemy for the first 2 days and was "mostly wiped out." His squad's "track" (APC) got separated from the troop and ran out of gas but his team was able to evade the enemy and walk back to a US unit. Then they got caught in an artillery barrage; one was killed, the sergeant was badly wounded and he himself got hit "like this." "There weren't no ambulances, but a supply truck took me and the Sarge from the aid station to the clearing station. I kept him alive in the truck, but they wouldn't let me stay and sent me here instead. I'm not crazy, Sir, and I'm not making this up. I can't fight like this! I can't walk! I can't even sit down to drive! I can't even sleep, it hurts so much!" (By now he is talking rapidly, nervous, almost in tears.) "Can't you give me some real medicine for the pain? Or send me to the hospital where they can?"

Past Medical/Social History: Single. Heavy beer drinking "in the barracks on weekends;" tried marijuana "in high school," but denies any since. No hard drugs.

DEVELOPMENTS AT LATER STAGES (to be filled in by evaluator)

Stage II:

Stage III:

Stage IV:

ACTION CHECKLIST

CASE P

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

	I	II	III	IV
Return to duty (time _____)	a	a	a	a
Return to Bde trains for rest & replenishment (time _____)	b	b	b	b
Return to unit for administrative action (time _____)	c	c	c	c
Return to Med Clr for evaluation or treatment (time _____)	d	d	d	d
Hold for rest, replenishment and RTD	e	e	e	e
Hold for rest and reevaluation	f	f	f	f
Hold for evacuation ASAP	g	g	g	g
Evacuated (time _____)	h	h	h	h
3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)				
a. Restraints	a	a	a	a
b. Medication (type? _____)	b	b	b	b
c. Special observation or evaluation? (what?)	c	c	c	c
d. Other (specify what and at what stage)	d	d	d	d
e. What did you tell the soldier? (specify stage I, II, etc)				

P

FURTHER DEVELOPMENTS

CASE P (Excessive Pain from Minor Wounds)

STAGE I ACTION → STAGE II DEVELOPMENT

- a. Returned after 12 hr as an unacceptable burden.*
- b. Returned after 24 hr as an unacceptable burden.*
- c. Put in punishment detail. No further feedback.*
- d. "I told you, he's medically clear!"*
- e/f. Complains of insomnia due to pain. Constantly asking for pain medicine.
- g. (If not evacuated by 6 hr) same as e/f.

STAGE II ACTION → STAGE III DEVELOPMENT

- a/b/c/d. Same as Stage I - II.*
- e/f/g. Eating well. Avoids other "battle fatigue" cases and does not participate in group ventilation.
- h. Overridden by Division Psychiatrist and Division Surgeon.

STAGE III ACTION → STAGE IV DEVELOPMENT

- a/b/c. Same.*
- d. Still medically clear.*
- e. Slept better, less complaints of pain. Has opened up in group ventilation, where his first days of battle with the "expendable" CAV has earned him much respect from some others.
- f. Same as Stage II - III f. Still complaining of pain.
- g. If not evacuated by 6 h, same as f.
- h. Evacuated.

*If this action/development is used, take the next development for this case from this same stage. (Make a note to here:)

Note: A's racial origin is irrelevant and should be selected as needed to achieve demographic balance among all cases. Gender must be male.

NOT USED

ACTION CHECKLIST

CASE _____

INTAKE TIME _____

TRIAGER: _____

1. INITIAL DIAGNOSTIC IMPRESSIONS:

2. ACTIONS: (Choose one at each stage as appropriate)

I II III IV

Return to duty (time _____)

a a a a

Return to Bde trains for rest & replenishment (time _____)

b b b b

Return to unit for administrative action (time _____)

c c c c

Return to Med Clr for evaluation or treatment (time _____)

d d d d

Hold for rest, replenishment and RTD

e e e e

Hold for rest and reevaluation

f f f f

Hold for evacuation ASAP

g g g g

Evacuated (time _____)

h h h h

3. SPECIAL INSTRUCTIONS (if given, specify and circle at what stage)

a. Restraints

a a a a

b. Medication (type?)

b b b b

c. Special observation or evaluation? (what?)

c c c c

d. Other (specify what and at what stage)

d d d d

e. What did you tell the soldier? (specify stage I, II, etc)

NOT USED

US ARMY INTERIM OPERATIONAL CONCEPT

FOR

ORGANIZATIONAL EFFECTIVENESS

(Edition - 2d Draft)

1. Purpose. To set forth an interim operational concept for Organizational Effectiveness (OE) which defines the doctrine, roles, and methods of operations for OE Consultants (OEC) on the extended battlefield.
2. Limitations: ^{Use of} Use of OE at joint or combined operations levels will initially be restricted by the availability of previously trained OEC and lack of documented authorization spaces.
3. Operational Concept:
 - a. General.
 - (1) The US Army may fight in a variety of places and situations against forces ranging in type from the highly modern mechanized forces of the Warsaw Pact to light, irregular units in remote parts of the world. Regardless of the opponents, the purpose of battlefield OE is to support commanders and staff, before, during and after the battle, in maximizing resources and capabilities while conserving forces in order to defeat the enemy and win.
 - (2) The doctrinal application of OE in deployed units in the theater of operations include assisting commanders and staff to:
 - (a) Develop and maintain a systems approach to the management of their organization.
 - (b) Reconstitute forces on the battlefield.
 - (c) Maximize and conserve human resources and materiel.
 - (d) Effectively execute command and control actions before, during and after the battle.

- (e) Develop and maintain trust among unit members.
- (f) Further develop combat capabilities based on evaluation of previous actions.

(3) General OE policy guidance is developed by the Director of Management, Office of the Chief of Staff, Army. The performance of OE services is decentralized within the area of operations. OE services are performed by OEC assigned to separate brigade, division, corps and echelons above corps (EAC). OEC's are normally assigned under the Chief of Staff of their respective organizations. The actual performance of OE operations in the field are tailored to the specific needs established by the commander and/or staff officer and the OEC.

b. Operational Overview: OEC assists commanders and staff:

- (1) Maintain a systems approach by:
 - (a) Focusing on the battle, battlefield and unit.
 - (b) Adapting to rapidly changing situations in order to capitalize on limited flexibility of the enemy.
 - (c) Respond to battle feedback from within the command to gain advantages over the enemy.
- (2) Maximize and conserve resources through:
 - (a) Reconstitution of units.
 - (b) Improving the effectiveness of unit procedures.
 - (c) Initiating procedures to enable units to plan for the future and be less reactive in the present.
 - (d) Improving time management.
- (3) Execute command and control actions to:
 - (a) Insure rapid, timely information flow.
 - (b) Enhance decision making.
 - (c) Focus on planned outcomes.
 - (d) Supervise the effective accomplishment of the battle mission.

(e) Provide a method for application of battlefield knowledge (lessons learned).

(f) Manage effectively battlefield stress.

(g) Foster effective initiative to gain clarity and purpose on issues rather than dealing with ambiguity.

(4) Developing and maintaining trust through:

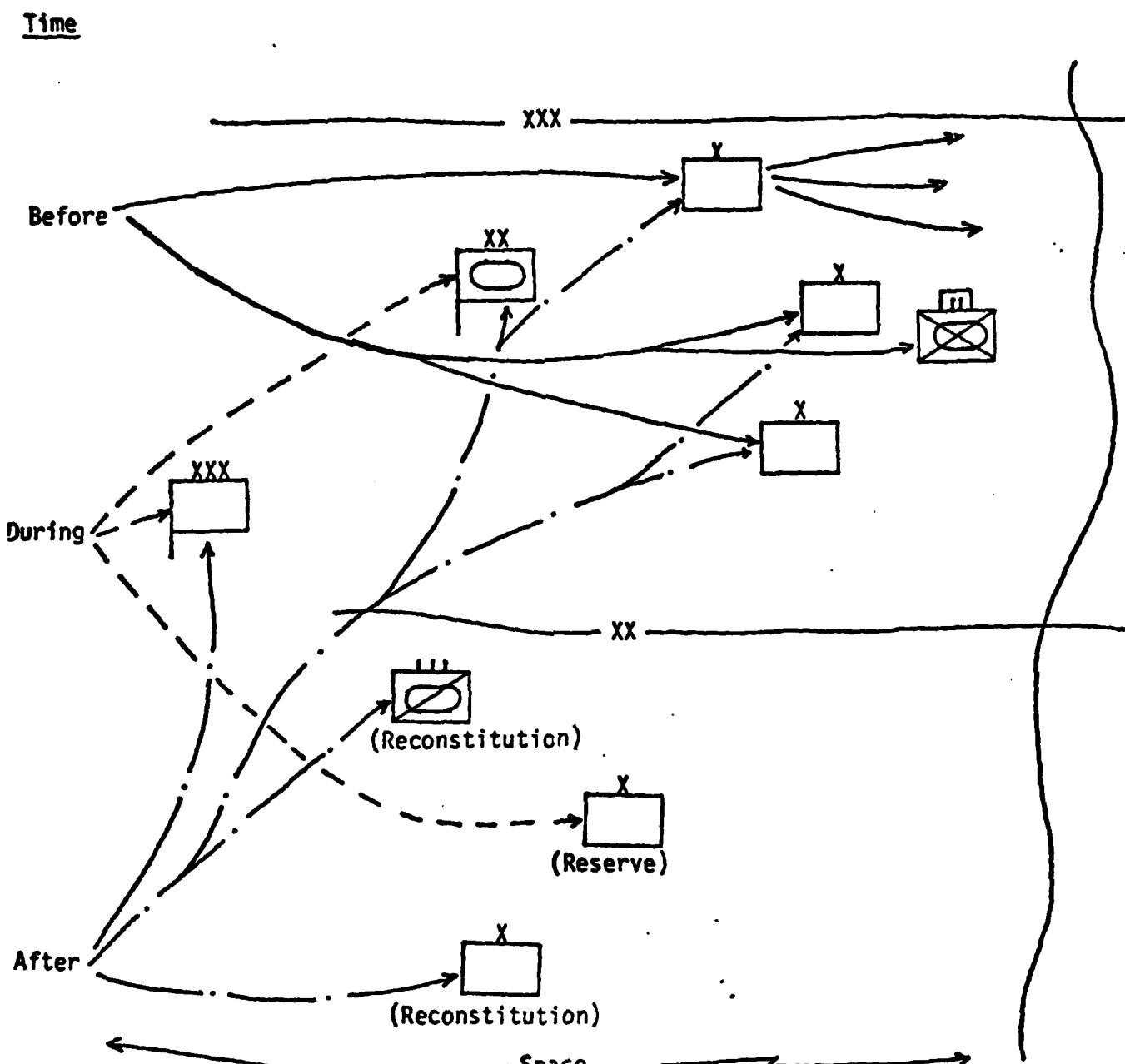
(a) Developing cooperation and mutual understanding among routinely attached task force elements.

(b) Developing and maintaining unit cooperation and cohesion.

(c) Developing and maintaining cooperation between battle elements.

(d) Building and maintaining unit esprit de corps.

c. Organizational Overview: The implementation of OE on the extended battlefield is accomplished along two dimensions: Time in relationship to the battle (before, during and after) and space represented by the geographical or physical location on the battlefield. (Figure 1 is a graphical representation of this concept. For purposes of simplicity, combat support and combat service support units are not depicted, but would receive OE assistance in accordance with the priorities established by the commander to whom OEC's are assigned.



*Forward Line of own Troops

Figure 1.

(1) OE Consultants apply the above doctrinal concepts in deployed units through:

- (a) Providing general consulting advice to commanders [and/or] staff officers on unit procedures.
- (b) Conducting assessments and providing specific feedback to commanders and staff on battle staff operations to improve Battle Staff Effectiveness (BSE).
- (c) Applying and transferring to commanders and staff officers, systems theory knowledge as it relates to the battlefield.
- (d) Providing consultation, coordination of reconstitution assessment teams (Appendix I, TRADOC PAM 525-4 and 5) and limited team building training for the reconstitution of units and staff organizations.
- (e) Team building to enhance unit cohesion and esprit de corps.

(2) General Consulting: The OEC provides general consulting services to commanders [and/or] staff officers. Priorities for use of OEC will be determined by the commander, or designated representative, of the organization to which the OEC is assigned.

(3) Battle Staff Effectiveness (BSE) applies to all types of organizations. The OEC observes and provides immediate feedback to commanders [and/or] staff members on the performance of battlefield functions of reconnaissance (knowing the situation), decision making (fit forces to the terrain, allocate means, assign missions, issue orders), communication and supervision (be forward, direct early movement of troops and sustain forces). In performing this function, the OEC moves freely through staff elements observing how, as well as what, actions are performed and serves as a coordinator at the operational levels of the staff.

(4) Application of Systems Theory to the battlefield. The OEC views the extended battlefield and units as an integrated system where action in one locale influences responses throughout a command. The OEC provides assistance to the commander and staff to develop and maintain a systems perspective and to respond to

feedback on the unit's ability to maintain that perspective.

(5) Reconstitution of Units: The role and function of OEC at Corps and Division vary with the overall requirement for reconstitution of forces. As a primary consultant to the commander on the reconstitution of forces, the OEC provides recommendations on the necessary composition of reconstitution teams at Division and Corps.

(a) At division level, the OEC performs the role of assessment coordinator for the division reconstitution assessment team. The OEC maintains the training of assessment team members in assessment technology, Analysis of Military Organizational Effectiveness (AMORE), gathering and collating assessment data and presenting the recommendations of the team to the Chief of Staff or designated representative. Based on the decision(s) made, the Division OEC becomes the primary point of contact for the Corps Reconstitution Team.

(b) The Corps OEC coordinates the efforts of the Corps reconstitution team through integration of the subsystems of:

- (1) Technology (equipment, techniques and resources);
- (2) Personnel (group dynamics, leadership, influence systems);
- (3) Mission (organizational missions, objectives and values) structure (establish patterns of relationships); and

(4) Command (planning, organizing, controlling and evaluation) to rebuild the unit.

The Corps and Division OEC work as a team to expedite the reconstitution effort.

(6) Team Building: Whether used in conjunction with the reconstitution of forces, enhancement of existing organization operations or the integration of active reserve component, or National Guard elements with deployed forces, the OEC designs and implements team building actions to enhance inter and intra unit cohesion. The principal focus of the OEC is to ensure the rapid transfer of knowledges and understanding that will improve combat effectiveness.

APPENDIX A

1. Analysis of Military Organizational Effectiveness (AMORE):

A structured approach to the building and integrating of functional teams of an organization. It identifies the critical elements or functions of organizations that define input degradation of military organizations into output capability as a function of time.

2. Battle Staff Effectiveness (BSE): The competence with which a unit performs the critical organizational processes of sensing, communicating information, decision making, stabilizing, communicating implementation, coping actions and feedback.

3. Systems Approach/Systems Theory: ^{and} A management science concept that states all organizations consist of a number of significant interacting variables which cut across or are common to all subunits of an organization. For example, the technological subsystem of equipment, procedures, methods and technical knowledge is common to all subunits of a Division. The interaction of systems theory states that changes within one significant variable (subsystem) will impact on all other subsystems within the organization. To continue with the technological subsystem example, the introduction of a new item of equipment will impact on the subsystems of tactics, (and/or) mission, command and control, personnel and structure.

4. Team Building: The process by which work relations are improved among members of some task group in an organization.

APPENDIX B

REQUIREMENTS

B-1. Doctrinal Requirements: Following publication of OE Doctrine applicable operational concepts and Field Manuals on Separate Brigade, Division, Corps and Echelons above Corps (EAC) must be modified to include the doctrinal use of OEC.

B-2. Equipment Requirements: Vehicles with suitable cross-country mobility and communications means are necessary to provide OE support to divisions, brigades, reconstitution teams, etc. OEC also will be provided sufficient weapons and other essential equipment for combat utilization.

B-3. Maintenance Requirements: OEC will be provided sufficient expendable supplies to perform required tasks. Repair requirements for vehicles, radios, weapons, and other equipment beyond individual capability will be provided by the organic unit.

B-4. The force structure of OEC offices will be sufficient to perform continuous combat missions. Minimum staffing levels for combat are two OEC per separate brigade, four per division, corps and EAC.

B-5. Training Requirements: OEC will be provided appropriate formal training by the OE Center and School to accomplish war and peace time functions.

MANNING THE FORCE FUNCTIONAL CONCEPT

1. PURPOSE. This paper sets forth the concept for manning the AirLand Battle 2000 with soldiers who have the skill and the will to fight to win.
2. LIMITATIONS. None.
3. DEFINITION. Manning the Force consists of those concepts, plans and programs which are directed at improving the skill and the will of our field soldiers to enhance their ability to execute the AirLand Battle 2000 doctrine given the weapons and tactics of the 21st century.
4. GENERAL. a. The AirLand Battle 2000 requires soldiers who can fight almost continuously using conventional and unconventional strategy and tactics to gain the initiative and defeat an enemy that may possess superior numbers and have technological parity with the United States. The anticipated battle is expected to be characterized by extreme life-death situations brought about by conventional, chemical, nuclear, biological, and directed-energy weapons. The day and night battle will place maximum stress both physically and psychologically on soldiers. In order to gain tactical initiative and provide survivability to our soldiers, U.S. forces must be able to react rapidly to engage in intense, prolonged combat operations immediately. Combat operations will be characterized by bold, imaginative plans which will require autonomous, independent small-unit actions with decision-making at the lowest level practical in order to exploit local tactical contingencies and gain the initiative over the enemy. The AirLand Force possesses the latest in high technology weapons, information processing equipment, and electronic intelligence-gathering capabilities. Such technology will also be available to our allies and the unconventional, surrogate forces that are organized by United States advisors to support the AirLand Battle.

b. The major combat multiplier on the AirLand battlefield is the will and skill of our soldiers. In order to operate effectively in the AirLand Battle, leaders must be capable of assisting and leading mature and sophisticated soldiers from diverse backgrounds who have a commitment to service and identity with their units. Leaders will be required to instill trust, an offensive spirit, and a warrior ethic in such a way that encourages bold, imaginative, and independent actions on the battlefield. Training systems must establish a training environment which will train soldiers to operate on the AirLand battlefield. Every effort is made to improve existing training technologies and to develop future technologies that support the doctrine, equipment, and soldier performance to enhance the ability of our soldiers and units to execute the combat operations of the AirLand Battle.
5. OPERATIONAL CONCEPT. a. General. In order to man the Force with highly skilled, dedicated and motivated soldiers, the year 2000 requires the Force to be able to operate effectively in four soldier technologies. They are:
 - (1) Leadership - the art of influence which enables AirLand Forces to function with a unity of purpose.
 - (2) Soldier Potential Developments - a field of study, research, and application that explores soldier capacities and develops soldier potential in order to fight effectively and survive on the battlefield.

(3) Soldier Skill Development and Training - Training systems and technologies which place effective soldiers onto the battlefield.

(4) Natural Technologies - A study and exploitation of areas and technologies that are considered to be "natural" for soldiers, so that these technologies can be harnessed into an integrated system designed to field a healthy, highly capable, inspired soldier. Examples of such areas are food, exercise, sports, music, and various mental activities..

b. Leadership causes, influences, and directs cohesive, technically proficient, and strongly motivated units. Emphasis is placed on building the will of soldiers to fight under extreme circumstances and on harnessing the capabilities of soldiers to work toward a common goal.

(1) Commanders not only try to positively orient soldiers, but provide situations where soldiers can develop themselves in their own personal evolution and self-actualization. Leader-influence strategies successfully integrate the values of the individual with the values of the organization. Leaders respond to soldiers who have a more world-wide and environmental perspective by integrating a sense of world community, global consciousness and ecological sanctity in the actions of units both in garrison and in battle.

(2) Leadership is a concern of everyone at all levels of the Force. The role of leadership in groups is a subject to be studied and taught at all levels. Leadership in long-term groups and groups undergoing reconstitution have priority of emphasis due to the nature of our Force and the battle.

(3) The AirLand Force has a climate of leadership that fosters trust, initiative, and lower-level decision making. Training institutions and field units mutually support each other in the building of a common leadership climate. Effective followership is given as much emphasis as effective leadership. The end result is soldiers at all levels who are capable of leading, following and fighting in all types of combat operations.

c. Soldier potential development is the set of those developmental activities that focus on the mental, physical, and spiritual capabilities of soldiers and how to harness such capabilities in fielding fighting units that can outperform enemy units.

(1) Testing, selection, classification, and training of soldiers carefully matches the requirements of the technology with the soldier to insure effective soldier-machine interface. Selection processes also determine which soldiers are "super fighters" and which soldiers are not capable mentally and physically of being "super fighters". Assignments of personnel to units and weapons systems insure that all combat units are composed of elite soldiers who are calm, swift, deadly, and possess the skill and the will to fight to win.

(2) Research into the functioning and processes of the mind will show how the mind works and provide details on the various levels of consciousness. This information allows soldiers to program and reprogram their mind and actions into a deadly warrior-fighting capability. Creativity and imagination are unlocked to provide units with soldiers who can plan and execute orders with maximum

alertness, adaptability and increased physical energy.

(3) The AirLand Force of 2000 will be a place where an individual can concern him/herself in personal self-evolution, a place where an individual can engage in activities that will assist him/her in finding their will to fight. This quest is programmed into the AirLand Force structure and training. Such self-evolution methods are individualized and can be mechanically assisted if the individual desires.

(4) Soldiers will find themselves more in control of their minds, bodies and reactions. Such freedom creates more autonomous, independent soldiers capable of fighting without regard to the size of enemy forces, the possibilities of retreat, with minimum regard for their own personal survival. Such soldiers are able to endure continuous combat day and night.

(5) Techniques for the control of human reactions will become commonplace. Soldiers will be able to control pain, stress, and other areas of their physical makeup. These techniques can be assisted by technology or may be self-directed.

(6) Technological aids will be available to enhance and multiply soldier powers. Tasks that now seem to require extensive training or knowledge will be routine with the aid of technology.

(7) The field of parapsychology will be further developed to provide the AirLand Force with soldiers and leaders who can perform mental and physical activities which defy explanation in the physical laws. Additionally, advanced physical, social and biological sciences may well begin to merge into one unitary theory of the universe which may open new soldier dimensions that are unknown today. These advances will have to be monitored and melded into military operations.

d. Soldier skill development and training systems will have to match the technology of the AirLand Force and the developments in the human potential arena.

(1) Advanced communication skills will enable soldiers to clarify not only interpersonal communication but also, interorganizational communications. In order to understand fully the commander's intent, subordinates initiate communications that will insure clearly understood orders. Such skills mean a knowledge and sensitivity to both verbal and nonverbal modes of communication. These skills will be employed in both face-to-face and in other means of transmitting information or communication.

(2) New learning strategies which speed the grasping and understanding of material provide soldiers with increased learning capabilities. Such learning strategies must simplify the level of complexity of future technology so that even the most seemingly difficult learning task is easily accomplished.

(3) Soldiers' skills will include the use of the media. Such skills as writing for newspapers, producing, directing, and acting in audio-visual material will be trained. This training will be used in molding both foreign and domestic public opinion.

(4) Organizing training and employing surrogate and unconventional forces add a new dimension to the AirLand Force capabilities. AirLand Force commanders and Close Combat Force (CCF) commanders employ these forces to complement their existing force. These training and organizing skills may be performed in the area of influence of the CCF.

(5) Soldiers in the AirLand Battle will have and use robots. Skills and knowledge concerning the use of such equipment is an integral part of initial and advanced training.

(6) Martial arts should be harnessed to train soldiers in a warrior ethic. Such training not only includes the physical aspects but also, the will to fight.

(7) Since there is increased probability of soldiers being exposed to lethal doses of chemicals or radiation without physical impairment, there may be large numbers of "walking dead". This new dimension to battle dictates that soldiers learn to face death and dying. Training in this arena stresses the cognitive and emotional responses to death.

e. There are technologies that are considered to be "natural" to soldiers. Such technologies are food, sleep, exercise, sports, play, music, and self-directed mental activities. These technologies can be harnessed to enhance soldier capabilities on the battlefield. Using this "natural" technology will enhance the soldier's ability to operate continuously in a high stress environment. Meditation for self- and Force enhancement is used to train and fight the AirLand Force.

6. FOCUS FOR DEVELOPMENT. Developments to enhance the soldier dimension of the AirLand Battle require:

a. Development of technological multipliers for soldier capabilities and machines that can enhance the level of functioning of soldiers on the battlefield. Some areas for development are:

- (1) Improving soldier and leader physical capabilities and senses,
- (2) Assisting in pain control and stress reduction,
- (3) Aids to inducing meditative states,
- (4) Enhancing creativity and imagination,
- (5) Assisting in advanced communications techniques,
- (6) Heightening the power of the mind,
- (7) Extremely low frequency radiation and its relation to brainwaves,
- (8) Other human technologies which offer great potential for improving soldier development.

- b. Developing selection and training that will match a soldier's physical and psychological capabilities with his weapon and his unit.
- c. Increasing understanding of mind functioning.
- d. Develop "natural" technologies that support personal and unit development in and during the AirLand Battle.
- e. Develop leadership and followership that enables units to integrate a more sophisticated, mature soldier of the future into cohesive units and groups.
- f. Develop self-evolution techniques for soldiers that make them better fighters and members of the AirLand Force.
- g. Advance the science of organization and group development to increase the capability of Airland Force units to reconstitute.
- h. Develop parapsychology to be a combat force multiplier.

NOT USED

LESSON PLANS

Draft lesson plans were contributed by COL James W. Stokes on "Psychological Aspects of NBC Warfare" and by CPT Terry Carroll (the remainder).

NOT USED

DRAFT

US ARMY ACADEMY OF HEALTH SCIENCES
BEHAVIORAL SCIENCES DIVISION
PSYCHIATRY AND NEUROLOGY BRANCH

LP 51-240-317

Psychological Aspects of NBC Warfare

COURSE PRESENTED TO: C22 Officers Advanced Course

PLACE: Classroom

REFERENCES:

1. Newhouse, P., F.D. Jones and G. Belenky. "Neuropsychiatric Casualties of Chemical Warfare" (paper presented to the Am Psychiat Assoc, N. Orleans, LA 1981).
2. The Medical Department of the US Army in the World War, Vol XIV "Medical Aspects of Gas Warfare," War Department, Govt Printing Office, Wash, DC, 1926.
3. "Medical Effects of Nuclear War," Armed Forces Radiology Research Institute, Bethesda, MD, 1979.

STUDY ASSIGNMENT: None

STUDENT UNIFORM AND EQUIPMENT: Duty uniform

TOOLS, EQUIPMENT AND MATERIAL: Screen, overhead projector or 35mm slide projector

PERSONNEL: One instructor (MC 60 W)

INSTRUCTIONAL AIDS: Transparencies or 35mm slides supplied by instructor

TROOP REQUIREMENTS: None

TRANSPORTATION REQUIREMENTS: None

TYPE OF INSTRUCTION: Lecture

I. INTRODUCTION (5 min)

A. Opening Statement. The Soviet Union is known to have significant numbers and types of tactical nuclear weapons plus various means to deliver them. A substantial proportion of their munitions (1 in 6, according to a neutral Swedish estimate) contain chemical warheads, while their forces are well-equipped to pass through (if not to fight in) contaminated areas.

Accidental epidemics in the Soviet Union strongly suggest the Soviets are also continuing to develop a biological warfare capability. If earlier study has not yet made you familiar with the characteristics and physical effects of each type of nuclear, chemical and biological threat, you are well advised to become so. This session will review the psychological implications of NBC Warfare. It cannot be denied that many of the NBC agents have

direct effects on the body and nervous system which may produce mental symptoms. Furthermore, the defensive measures which can be taken against these agents exact a heavy psychological price. Finally, the very nature of the threat, even if it is never used, can have a profound psychological impact on the inadequately prepared soldier. Only by facing these psychological issues squarely can we develop a credible deterrent which will make the threat less likely. If, then, a tactical nuclear/chemical/biological battle must be fought, we will also be best equipped to win it.

B. Objectives

1. Identify and discuss elements of the NBC threat which make psychological reactions and maladaptive behavior especially likely.
2. Identify and discuss types of maladaptive behavior and psychological reactions which are likely.
3. Identify and describe psychiatric symptoms due to inappropriate antidote use, incapacitant agents and sublethal doses of nerve agent and their differentiation from other NP conditions.
4. Identify and discuss correct approaches to preparing psychologically for NBC battle, as discussed in class.

II. EXPLANATION (60 min)

NOTE: Use transparencies or 35mm slides to support lesson plan.

A. Operational characteristics of the Integrated Battlefield which create psychological hazard.

1. Some agents are:
 - a. Invisible & odorless
 - b. Persistent
 - c. Have delayed effects
 - d. May be contagious
2. Delivery modes (rockets, aerosols from aircraft, artillery) are:
 - a. Non-specific

- b. Common on any battlefield
- c. May be covert

3. Detection methods are:

- a. Incomplete
- b. Perhaps insensitive
- c. Local and vulnerable (Murphy's Law)

4. Early signs and symptoms of exposure may be:

- a. Common, non-specific
- b. Too late

5. Consequences of delaying treatment may be:

- a. Irreversible disability
- b. Disfigurement
- c. Immediate or delayed death

B. Result: An implied demand on soldiers and commanders to make critical judgements based on information which is too vague or too random to give a reliable answer.

1. Psychology experiments have shown that attempting to discriminate the indiscriminable causes "experimental neurosis"

NOTE: Pavlov conditioned dogs (classical conditioning) to salivate when showed a circle, while they did not salivate for an ellipse. Pavlov then made the ellipse progressively rounder. The dogs became anxious, cowered and resisted being put in the experiment even though there were no negative consequences to salivating for the ellipse. Other learning experiments have shown the same result in different settings in which the animals also developed habitual ways of making the choice which they then couldn't change even if ineffective.

2. The common result of trying to discriminate the undiscriminable is severe anxiety, withdrawal or, if unable to withdraw, the development of inflexible, sometimes maladaptive and even bizarre responses.
3. Because the stimuli of chemical and biological warfare (if not of nuclear war) are so ambiguous, we must anticipate maladaptive psychological reactions under the imminent threat of use alone, even if they are never used.

C. Maladaptive reactions to NBC threat.

1. Increased incidence of conventional "Battle Fatigue" due to the heightened uncertainty and strain.
 - a. Rates may exceed the projected or base ratio of one Battle Fatigue case admitted into the medical system for every three WIA, and can even exceed 1:1 in heavy sustained conventional fighting by inexperienced or surprised units who are obliged to hold the ground.
 - b. The wide range of Battle Fatigue syndromes, their treatment and prevention, are covered in other lesson plans.
2. "CBR Conversion Hysteria" or "Integrated Battle Fatigue" symptoms due to the mistaken belief that one has been exposed to a chemical, biological or radiational agent(including laser and microwave effects").
 - a. May become epidemic within small groups due to social "amplification" of normal anxiety symptoms such as hyperventilation or hysterical syndromes.
 - b. World War I estimate: 2/3 of those treated in medical facilities for gas exposure had never been exposed.
 - c. World War I "gas mania" usually involved respiratory distress symptoms and speech difficulty; if not correctly diagnosed and treated promptly with reassurance and return to duty, the symptoms became a permanently disabling "gas neurosis".

- d. The modern range of NBC weapons may provoke a wider variety of "hysterical imitations" and require special medical/psychiatric expertise for differential diagnosis far forward in the battle area.
3. "Panic flight" - may infect individuals or entire units if they feel unprepared, perceive that their protective measures aren't working (as they may well not in a "hysterical" epidemic), and fear that escape is being blocked off.
4. Susceptibility to spreading and believing rumors (due to heightened anxiety).
 - a. May create undue concern for family in the combat theater or CONUS and distract from the combat effort.
 - b. Will require exceptional leadership efforts to stop rumors, retain trust and spread valid information.
5. "Hypochondriasis" and increased sick call due to preoccupation with detecting early warning symptoms.
6. "Obsessive-compulsive" over-concern with decontamination procedures-may result in costly, time consuming "rituals" or even skin problems due to overuse of harsh decontaminants.
7. "Phobic anxiety" of perceived sources of contamination:
 - a. May include food & water, unit's vehicles; stragglers, refugees and casualties; geographical areas and objectives.
 - b. May result in total avoidance, refusal to obey orders, or just such high anxiety levels that efficiency is impaired.
8. "Inappropriate fatalism" and denial. There's nothing we can do to protect ourselves anyway, so lets forget about it")
 - a. If esprit de corps and belief in possible ultimate victory are maintained, units will still fight "to the death" but may fail to take NBC precautions.
 - b. If those factors are lost, individuals or cohesive groups may desert the fight for "one last fling".
 - c. In either case, alcohol or drug abuse may increase to assist in the denial.

9. Overconfidence ("We've made it this far without taking casualties. There's really no danger after all")
10. "The boy who cried wolf" effect (after the inevitable false alarms, "Will that idiot stop banging metal on metal again so I can get some sleep?")

NOTE: These psychological ways of ignoring the problem may be more common than the "over-reactions", and lead to failure to take sensible precautions and abandonment of equipment. Only the right kind of peacetime training, based on doctrine and SOPs which minimize the need for ambiguous discriminations, can control both the over-reactive and under-reactive types of maladaptive response.

D. Psychological Consequences of Mission Oriented Protective Posture (MOPP).

1. As long as the threat of chemical warfare is taken seriously (and certainly if it is begun), troops will have to don masks and perhaps spend hours in various levels of MOPP.

NOTE: Instructor may use Q & A technique to elicit class's personal experiences of each of the following psychological problems in MOPP.

2. Sensory, motor and perceptual consequences:

- a. Gloves decrease tactile sensation, fine motor movement
- b. Mask distorts vision, decreases peripheral fields, interferes with weapons sights, may fog up. Special problem if need prescription lenses.
- c. Mask muffles and distorts speech; especially bad for radio communication
- d. Increases frustration, respiratory effort and fatigue
- e. May cause claustrophobia, hyperventilation, panic, or just premature unmasking.

NOTE: Imitation by others caused mass casualties in WWI.

3. Heat stress

- a. Just standing in full MOPP adds 10 degrees to the WBGT or Botsball index; performing physical work generates additional heat which builds up rapidly and can be dissipated only slowly even in cool weather.
- b. Heat buildup and sweating inside the ensemble are distracting and can give cramps or fainting. (heat exhaustion)

QUESTION: What is likely to be the first signs of someone getting heat stroke in MOPP?

ANSWER: First shows as confusion, disorientation, then delirium with hallucinations and delusions as body temperature rises above 105 degrees F.

NOTE: Heat stroke will be a difficult differential diagnosis from other possible causes of "crazy behavior" on the battlefield- but probably only for the 91B aidman, since if he doesn't cool the soldier down somehow, it will be too late by the time the case reaches the Bn Aid Sta.

4. Discomfort and hygiene issues

- a. Can't eat with mask on; can drink only through special canteen tube-may contribute to dehydration, salt deficiency and heat exhaustion; will require special command emphasis on water intake.
- b. Urination in a potentially contaminated environment is risky, and defecation supposedly requires a buddy to assist with the garment. Many may choose constipation instead (as they do in the Arctic), but what about those who get diarrhea?
- c. Sweat immersion and possibly other soil will contribute to skin irritations; itches will be hard to scratch, gross fungal disease may develop.

NOTE: MOPP gear is a "portable jungle." If high MOPP levels must be maintained for frequent or prolonged periods, effects on hygiene, health and morale could approach those seen in S. Pacific WW II.

- d. Sleep in the mask will be difficult due to discomfort and respiratory effort

5. Psychosocial effects:

- a. Difficult to recognise team members by sight or voice; risk of infiltration enhances "paranoia"
- b. Can't gauge a person's alertness, comprehension or willingness to act by usual non-verbal signs; will require special leadership techniques.
- c. Conversation & social interaction difficult-feeling isolated may decrease group cohesiveness?
- d. Sense of isolation, being alone, a prime factor in Battle Fatigue.

E. Psychological effects of Antidotes and CW Agents

- 1. Atropine issued to troops in three 2 mg autoinjectors as immediate antidote for nerve gases (NG).
 - a. May be administered in absence of NG exposure due to false alarm or deliberate drug abuse; effects stronger if there is no NG to counteract.
 - b. Atropine (2-6 mg) will:
 - (1) Blur vision for near objects, increase heart rate, dry mouth, suppress sweating, increase risk of heat stroke
 - (2) Probably impair attention, short-term memory, judgement and insight.
 - (3) May cause urinary retention (which is distressing!)
 - c. The "official" toxic dose for Atropine is above 10 mg, but sleep deprivation and physiological stresses (heat; fluid and electrolyte imbalance; hyperarousal) may lower the threshold for an acute psychotic state as they do in physical illnesses.
 - d. Acute anti-cholinergic Delirium due to atropine overdose involves:
 - (1) Confusion, fluctuating level of awareness, disorientation to time and place (but rarely to own person)

- (2) Delusions (usually fearful), agitation, and vivid hallucinations (often visions of nasty small creatures and fire, but also sometimes sensations of bugs under the skin, bad smells, or even voices)
- 3. Associated physical findings of widely dilated pupils; hot dry and perhaps red skin; dry mouth.
- 4. Seizures, cardiovascular collapse, high fever, coma and death are possible at high doses.

F. Treatment:

- 1. Physostigmine quickly relieves the symptoms but must be titrated carefully for some hours to prevent relapse (which may not be feasible in field mass casualty situations).
- 2. Control of agitated behavior may require physical restraints, diazepam (valium) or haloperidol (Haldol).
- 3. Do not use chlorpromazine (Thorazine) as its' anti-cholinergic side effects will make the atropine effects worse.
- 4. Pyridostigmine (a carbamate anti-cholinesterase drug like Physostigmine):
 - a. May someday be issued as a pre-exposure protection against the nerve gases.
 - b. However, it may cause psychiatric depression in some individuals.
- 5. TAB (TMB-4/Atropine/Benactazine)
 - a. Has been withdrawn from Army use because the Benactazine virtually guarantees visual hallucinations.
 - b. Is still relied on by the USAF and USN, who feel it gives better defense against the "fast-aging" persistent agent Soman. (USAF guidance for pilots taking TAB is "inject, then eject")

6. BZ, an "incapacitant" chemical agent which may be used, is a more potent and longer acting anti-cholinergic than Atropine.
 - a. BZ delirum may last 24-72 hrs.
 - b. Treatment is the same as Atropine's.

NOTE: Other hallucinogenic incapacitant agents (LSD, etc) could also be employed and should also not be treated with Thorazine.

NOTE: Program 20 min break about here.

7. The Anticholinesterase "Nerve Gases" (non-persistent= Sarin (GB); persistent=thickened Soman (GD) and VX)
 - a. Low dose exposure more likely than high dose due to dispersion and protective measures, and may occur repeatedly without treatment.
 - (1) May produce effects similar to those of related organo-phosphate insecticides.
 - (2) Immediate psychological symptoms: inattention, impaired judgement and thinking, rare acute delirium.
 - (3) Chronic psychiatric symptoms can last months to years: depression, sleep disturbance with bad mood, irritability, impulsiveness (looks like combat stress reaction).
 - (4) Reportedly may also precipitate schizophrenia in predisposed individuals.
 - b. High dose exposure rapidly fatal unless treated with atropine plus oxime (2PAM); if patient survives, the chronic psychiatric symptoms described for untreated low doses still occur and last for months to years.
8. Tear gases, choking and vomiting agents
 - a. Maybe used alone or in combination with lethal agents to make soldiers unable to stay masked.

- b. Symptoms (lacrimation, irritation) simulate early signs of lethal agents and may trigger panic or inappropriate antidote administration.
- 9. Blood agents (cyanide gases AC & CN) may be used by Soviets as a very non-persistent lethal agent at the point of attack; CN also inactivates mask filters.
 - a. Low dose symptoms mimic anxiety and hyperventilation; i.e. giddiness, shortness of breath, rapid heart beat.
 - b. Amyl nitrate (the antidote, in packets to be popped and inhaled) definitely has potential for recreational abuse, and so is currently not issued to the troops but is kept by the medics.
- 10. Blister agents (the mustards, lewisite)
 - a. Sublethal delayed systemic effects:
 - (1) Psychiatric depression
 - (2) Impaired wound healing and increased risk of fatal infection-may be psychological (and ethical?) bar to return to duty.
 - b. Psychological implications of contagion plus delayed effects:
 - (1) Mustard's skin lesions may not show until hours after soldier is wounded and evacuated to medical facility-this led to the blinding by corneal exposure of entire surgical teams in WW I.

NOTE: The persistent nerve gases also are "contagious" but are less likely to be a surprise because of their quick action. Infections, biological agents could have delayed contagious effect.

- (2) Fear of contamination by casualties will place special strain on buddy aid, medical evacuation and medical care.

G. Psychological effect of Nuclear Weapons

NOTE: (1) Enhanced radiation weapons ("neutron bomb") currently a US monopoly, but could irradiate nearby US troops.

(2) Soviet tactical nukes

- (a) Less likely to produce instant irradiation without associated blast or burn injury.
- (b) Makes more residual fall-out which can give sub-lethal radiation dose downwind if troops don't seek cover.
- (c) Fallout, like gas is an "invisible, persistant, delayed" threat.
- (d) Less protection from CBR ensemble.
- (e) Defense is to escape area (source of panic?) or "go to earth", dig in and wait for all clear (source of Battle Fatigue symptoms unless good leadership)
- (f) Must avoid ingesting fallout

1. Heat and blast-will cause horrible burns and injuries in exposed personnel;
 - a. This likely to have greater psychological impact/revulsion on the uninjured than would mass CW casualties.
 - b. May produce "disaster shock" syndromes (types of "Battle Fatigue") just like other sudden violent events.
 - c. 1st use of nuclear weapon also may increase concern for families in theater and CONUS if the war becomes global.
2. Retinal burns
 - a. Localized damage to retina from the intense image of the fireball.
 - b. Damage to central retina will give severe permanent loss of visual acuity.
 - c. Damage to the peripheral visual fields may subsequently be almost undetectable, but this won't be obvious for minutes to hours until flashblindness clears.
3. Flash blindness

- a. Temporary diffuse loss of visual acuity lasting seconds to minutes, due to glare.
- b. Severity and duration depends on distance and orientation to fireball, atmospheric conditions (worse in darkness)
- c. Likely to impair performance, perhaps cause accidents.
- d. May cause fear of permanent blindness unless troops well educated that this is temporary.

4. "Hysterical blindness" as a "conversion reaction" ("Integrated Battle Fatigue") may persist after the flash blindness should have cleared.

NOTE: Similar local retinal burns result when the existing big laser range-finders and designators shine directly into the eye from up to 2 km away (and further, if viewed through optics; damage will be obvious if a blood vessel is ruptured or the sensitive central retina is destroyed, but may go unnoticed if only a peripheral part is destroyed. This hazard seems especially likely to promote conversion reactions of blindness.

5. Nuclear radiation

- a. Acute irradiation; depending on dose, produces a spectrum of illness ranging from minimal to fatal within hours. Common pattern of symptoms if not rapidly fatal:
 - (1) May give "prodromal" symptoms of nausea, vomiting, malaise, headache several hours after exposure and lasting hours to day.
 - (2) Then "latent period" of relative well-being for days to 1-2 weeks when soldier could perform effectively but is at higher risk of complications if wounded.
 - (3) Symptomatic "radiation sickness" returns with hair loss, GI sloughing, blood disorders, decreased resistance to infection.
 - (4) Dose received by individual soldier probably unknowable, and estimation by symptoms in the prodromal and latent periods is subject to psychosomatic factors.

NOTE: Suppression of lymphocytes (White Blood Cells) in the Complete Blood Count (CBC) over several days after the exposure provides the best predictor of subsequent radiation sickness severity, but field medical facilities have very limited capability to screen large populations.

b. The Ethical Dilemmas for AMEDD and Command:

- (1) What to tell the soldier about his/her chances when you can only guess what the odds are?
- (2) If believe dose was greater than LD 100 (600 rad)
 - (a) Can soldiers be prepared psychologically to RTDTD (Return to Duty to Die) as kamikazes?
 - (b) Should they be encouraged to be blood donors?
- (3) If believe dose was in the LD 1 to 90 range (150-500 rads)
 - (a) Should the latent period be used to evacuate the stabilized patient to facilities where can best protect against infection and injury during the radiation sickness phase?
 - (b) Or should he/she be returned to duty in spite of increased susceptibility to death?
- (4) If believe dose was less than LD 1 (150 rads)
 - (a) May not have early "prodromal symptoms" or develop overt manifest late symptoms.
 - (b) Soldier could RTD, but still at increased risk of death during latent period and especially if develops manifest radiation sickness.
 - (c) Cumulative low dose irradiation (less than 50 rads per dose)
 - (1) Unlikely to have overt physically-caused symptoms but may have psychosomatic ones if exposure feared.
 - (2) Long-term cancer and fertility risks are generally known to troops; short-term wound and infection risks also still apply.
 - (3) Units may (should) be estimating cumulative dosage; may promote mass "old sergeant syndrome" as approach critical levels.

- (4) AMEDD must be prepared to help command weigh the risks in perspective.
- (5) Remember AMEDD not immune themselves.

H. Psychological preparation for NBC Warfare Battle

QUESTION: How can we prepare? Isn't the modern battlefield more lethal than any in history?

ANSWER: No, modern weapons are more lethal, but the battlefield is much less so, in terms of the casualty-rates per unit time, because forces are more dispersed

QUESTION: But aren't the mass casualties that nuclear weapons could produce unheard of?

ANSWER: No, (altho the medical care which can be given afterwards is better).

EXAMPLES:

- (1) Battle of Cannae (Hannibal vs the Romans, 226 BC)
48,000 Romans + 6,000 Carthaginians & Gauls
killed out of 119,000 engaged in square mile in a day.
- (2) Battle of the Somme (British vs Germans, 1915)
60,000 British casualties (21,000 dead) out of those committed on a 15 mile front, most of them in the first hour. (The battle lasted 4 months and cost the British 500,000)

QUESTION: But can't chemical weapons now kill everyone on the battlefield?

ANSWER: NO.(1) They can only be delivered to local areas which are small compared to the entire combat zone, then either disperse or persist in that spot.

- (2) CW is easier to defend against than bullets and explosives; used extensively in WW I (along with massive artillery, machine guns, etc.), it was decisive only against the unprepared.

- (3) CW in WWI caused for more "wounds" than deaths (about 50:1, compared with 3:1 for battle wounds)
- (4) Use was also limited because CW proved almost as likely to harm the user as the target.

QUESTION: But aren't the Soviets prepared to fight in the CW environment?

ANSWER: No, they are prepared to drive and shoot their way through it, then to deploy on the other side. If we, as the defender with lethal long range weapons, can force them to dismount and attack in their CW area, their primitive individual protective ensembles will put them at a serious disadvantage.

QUESTION: But can anyone tolerate such extreme discomfort, restricted vision and hearing, heat stress, and risk of contagious illness?

ANSWER:

- (1) The Crusaders did, when they fought in full armor and helmets in the Holy Land. There are many other examples which show how.
- (2) The solutions were (and still are) physiological acclimatization, psychological hardening to discomfort, realistic training in the tasks to be performed, and rigorous preventive medicine discipline.

H. Prescriptions for a credible NBC defense:

1. Develop team SOPs which give a flexible level of protection at less psychological cost.
 - a. Need greater flexibility than MOPP 1 to 4; as even MOPP 1 seriously limits activity.
 - b. Most threats can be reduced just by masking plus using overhead cover (or mask plus poncho).
 - c. Make SOP that some members of unit mask and perhaps assume safer MOPP level to provide backup "cover" for those who must perform heavy or sensitive work.

- d. By decreasing the "price" (risks) of the defensive measures, they become easier to use (and easier to learn!)
- 2. In training, stress Professionalism and Positive Coping not Fear.
 - a. Knowledge of the threat is important to get attention and understand protection, but must not stimulate paralyzing fear or denial.
 - b. Avoid "one-shot" gas chamber CS exercises which only condition anxiety and physical symptoms to the mask!
 - c. Make using the mask (and occasionally higher MOPP) a matter of routine-(mask is like helmet-not comfortable, but something soldiers wear while we work, because we're soldiers.
 - d. Perform all necessary tasks in MOPP routinely to learn how to compensate.
 - e. Accept the risk of ^{treatable} heat injury in acclimatized troops, and practice preventive water discipline, self-pacing, early detection of signs and immediate correct treatment. (Greater caution is still necessary for the unacclimatized).
- I. Practice SOPs for when to increase defensive posture and when to decrease.
 - 1. Do not wait for human bodies to be their own detectors!
 - 2. Use simple, non-subjective stimuli, e.g., anytime unit receives incoming artillery or an aircraft flies nearby, or a casualty is brought to the MTF.
 - 3. In potential risk situation, some members of unit should be at some protective level at all times, with a MOPP rotation system set by SOP.
 - 4. Stress buddy aid by those already in protective posture rather than self-aid.
 - 5. Do not rely heavily on chemical detection instruments for early warning; their best value is to identify type of agent and to indicate all-clear.
 - 6. All-clear SOPs should also specify team sequence for unmasking

7. Develop cohesive units with 'esprit de corps', good leadership techniques, stress management skills, etc. Sense of purpose and religious faith also valuable.

J. Questions from students

III. SUMMARY (5 min)

A. Review of main points

1. Operational characteristics of the integrated battlefield which create psychological hazards.
2. Likely maladaptive reactions to NBC threat.
3. Psychological consequences of MOPP.
4. Psychological effects CW agents & antidotes
5. Psychological effects of nuclear weapons
6. Ways to prepare psychologically.

B. Closing statement. The Nuclear Biological Chemical battlefield sounds unendurable, but we must not underestimate human resilience. Military History is the recurring story of determined, cohesive units who endured the un-endurable and even, amazingly, came to accept it as commonplace. It is not our objective here to discuss whether a tactical NBC war could necessarily become a global strategic one, or whether the world after such a global exchange would be worth living in. It would certainly be very different. But our job here is deterrence, and the history of the non-use of chemical weapons by any side in WW II is the classic demonstration that deterrence works. By making it clear that we are physically and psychologically prepared to fight on a nuclear/chemical/biological battlefield, we stand our best chance of never having to.

IDENTIFY COMBAT STRESS PHENOMENA

ADMINISTER FIRST AID TO A CASUALTY SUFFERING COMBAT STRESS

I. INTRODUCTION:

A. Opening Statement: In combat, soldiers experience conditions of overwhelming stress. Examples of conditions which may produce combat stress include physical exhaustion, the requirement to be constantly alert, the trauma of seeing fellow-soldiers wounded or killed, the fear of being killed or maimed, and the necessity of killing. Temporary (transient) debilitating psychological disorders may develop, even in previously stable personalities. Combat stress reactions are generally not so incapacitating as to demand removal from combat. However, when a soldier can no longer function effectively on his job, the medical specialist, or other soldiers, may provide appropriate initial treatment or psychological first aid.

B. Objectives:

1. Identify terms related to combat stress reaction.
2. Recognize common reactions to combat stress.
3. Provide initial treatment.
4. Identify evacuation requirements or return soldiers to duty.

II. EXPLANATION:

A. Recognize and identify the terms which are related to stress reactions in combat.

1. Combat Stress Reactions - Combat stress reactions are emotional reactions that are temporary in character. They are experienced by every person who undergoes the stress of combat. This term encompasses both battle fatigue and transient battle reactions.
2. Transient battle reactions - Transient battle reactions are temporary debilitating psychological disorders. Reactions usually subside following rest and initial treatment, for an estimated 80% to 90% of the cases. Soldiers not previously engaged in combat may experience transient battle reactions but rapidly adapt and learn to bear considerable stress.
3. Battle fatigue - Battle fatigue refers to fatigue due to length of time in combat. Stress tolerance becomes lower after a period of time. Reactions that occur include impairment of self-confidence, trembling, irritability. Battle fatigue may occur in a unit which has been in continuous combat.
4. Fear - Fear is an emotion experienced in response to real danger.

5. Anxiety - Anxiety is an expectation of danger, involving feelings of apprehensiveness, uncertainty, and insecurity.
6. Depression - Depression can refer to feelings (mood) of sadness, despair, discouragement, and as such may be a normal state. Depression which may be disruptive to the soldier is commonly manifested in slowed thinking processes, decreased purposeful activity, guilt, self-condemnation, hopelessness, and disorders in eating and sleeping. Depression may develop during a lull in combat or as a post-combat behavior.
7. Lethality - Lethality refers to the accuracy and killing power of modern weapons. The high intensity and the greater deadliness of modern weapons will increase the level of psychological stress. The battlefield environment may now include the possible use of nuclear, biological, and/or chemical weapons. The number of soldiers killed in action and wounded in action is the major contributing cause to an increased rate of combat stress reaction.
8. PIE - PIE is an acronym for the principles of treatment for soldiers suffering from combat stress reaction.

P = Proximity
I = Immediacy
E = Expectancy

An estimated 80% to 90% of soldiers receiving treatment in accordance with these principles develop no long-term disability. Also the chances of later psychiatric problems (delayed or hidden reactions) are reduced.

- (a) Proximity - Treatment as near to the front lines as practicable increases the potential for full recovery.
- (b) Immediacy - Initial treatment (psychological first aid) should be applied as soon as possible.
- (c) Expectancy - Expectancy refers to ideas that the medical specialist should get across to the soldier.
 - (1) Expectancy refers to ideas that the medical specialist should get across to the soldier.
 - (2) The medical specialist should instill the expectation of rapid recovery after a brief rest. He should avoid giving the impression of an incurable mental illness.
 - (3) The soldier is expected to return to combat. The soldier will realize that his skills are needed and that he is a part of the team. In this way, the soldier is also reassured that the combat stress reaction is only temporary.

B. Observe and recognize common reactions to combat stress.

The medical specialist will observe a range of reactions to fear, anxiety, and depression. These reactions affect all soldiers to some degree. The medical specialist will recognize the range of manageable reactions that are expected to be found in combat. However, he must also be able to recognize those soldiers with disruptive (more severe) stress reactions.

Not all combat stress reactions can be recognized quickly by the medical specialist. His observations of changes or modified behavior among known personnel in his unit could identify early stages of stress reactions. In many instances, the medical specialist may have to rely on information from supervisors or close associates of the soldier.

1. Manageable Reactions

a. Muscular Tension

- (1) Headaches - Muscular tension increases under stress. Examples of reactions are: headaches, inability to relax, cramps.
- (2) Inability to relax - Muscular tension is disruptive when the soldier can no longer maintain his own safety or that of others.

b. Shaking and Tremor

- (1) Mild shaking - Mild shaking may appear when undergoing shelling or bombing. It appears and disappears rapidly and is a normal reaction to conditions of great danger.
- (2) Marked or violent shaking - Marked shaking is sometimes incapacitating; it may also persist after the precipitating stimulus has ceased.

c. Perspiration - It is normal to experience either mild or heavy sweating, or sensations of chilliness, under combat stress.

d. Reactions of Digestive and Urinary Systems

- (1) Nausea and vomiting - Vomiting may occur immediately, after fire fight, shelling, etc.
- (2) Loss of appetite - Appetite loss becomes a significant problem if rapid weight loss occurs, i.e., 5 lbs per week or more.
- (3) Abdominal distress - Acute abdominal pain may occur during shelling. Persistent and severe abdominal pain is a disruptive reaction.
- (4) Urinary frequency, especially at night
- (5) Diarrhea - Inability to control bowel and/or bladder functions may occur under catastrophic combat stress. Persistent inability to control bowel and/or bladder functions (after stress stimulus ceases) is a disruptive reaction.

- e. Reactions of Circulatory and Respiratory Systems - Elevated blood pressure and increased pulse rate are common reactions to stress.
 - (1) Heart Palpitations - Rapid heartbeat, a sense of pressure in the chest, chest pains may be noted.
 - (2) Hyperventilation - Hyperventilation may be identified by rapid respirations, shortness of breath, dizziness, a sense of choking.
 - (3) Sensations of faintness and giddiness - These reactions may occur with physical fatigue and extreme stress, together with generalized muscular weakness and lack of energy.

- f. Sleep Disturbances

- (1) Difficulty in falling asleep - Sometimes a soldier cannot fall asleep even on those occasions when the military situation permits. Some persons cannot sleep in the absence of a specific disruptive stimulus, such as combat noise. The military situation may call for continual alertness. The physical environment may not permit restful sleep, e.g., cold weather, heat, lack of food, water, insects.
- (2) Nightmares - Terror dreams, battle dreams, and nightmares of other kinds may cause difficulty in staying asleep. Sleep disturbances in the form of dreams are part of the coping process. This process of "working through" combat experiences is a means of increasing the level of tolerance of combat stress.
- (3) Restless sleep - When a person is asleep, the sleep may not be restful (refreshing) sleep. The individual wakes up as tired as when he went to sleep.
- (4) Excessive sleep - Sometimes soldiers may sleep excessively. Whenever they are not fighting, they sleep. Excessive sleep may be a sign of substance abuse or depression.

- g. Visual and/or hearing problems, partial paralysis

- (1) Stress-related blindness, deafness, partial paralysis are not true physical injuries. They are physical symptoms which enable the individual to escape or avoid a stressful situation.
- (2) Some individuals unconsciously use physical illness as a face-saving means of coping with the stress of combat. Among combat personnel in World War II, such stress-related reactions were common.
- (3) Individuals with these conditions are very concerned with their symptoms and willingly discuss them; they do not mind being examined. This is in contrast to persons who are simulating (faking) a physical illness, who are reluctant to talk and do not want to be examined.

- (4) Visual problems include blurred vision, double vision, difficulty in focusing, or total blindness.
- (5) Inability to hear orders or nearby conversations, or complete deafness, may occur.
- (6) Paralysis is usually confined to one arm or leg. Prickling sensations, tics, or rigidity of the larger joints may occur.

h. Death Anxiety (Fear of Death, Pain, Injury)

- (1) Fear of death, pain, injury soon cause anxiety reactions. After a soldier has been in combat and has seen many of his buddies killed and wounded, he loses whatever feeling of invulnerability he may have had.
- (2) The death of a buddy leads to a serious loss of emotional support. Feelings of guilt may also occur. The soldier may have felt glad that it was not himself who was killed. He may feel guilty about having such feelings.

i. Bodily Arousal

- (1) In response to threat, the brain sends out chemicals that arouse the various body systems. The body is ready to fight or take flight.
- (2) Hyperalertness - Hyperalertness refers to general focusing on certain external stimuli that might signal danger. A soldier who is hyperalert is ready to respond immediately to danger. His senses are alert to danger. His senses are alert to possible threats. Example: The noise of a mortar being fired will probably wake up a soldier and send him running for cover long before a shell hits in the vicinity.
- (3) Startle Reactions - Startle reactions are part of an increased sensitivity to minor external stimuli (on-guard reactions). Leaping, jumping, cringing, jerking, or other form of involuntary self-protective motor response to sudden noises may be noted. The noises may not necessarily be very loud.
- (4) Startle reactions may occur not only to noises but also to sudden movement or to sudden light. Example: the sound of taking cellophane off a piece of hard candy may cause someone to jump and become angry. Unexpected movement of an animal (or person) may precipitate weapon-firing.

j. Irritability - Irritable reactions range from angry looks or a few sharp words to acts of violence.

- (1) Snappishness, verbal flareups, and tears - Irritability is manifested externally by snappishness, overreaction to normal, everyday comments or incidents, flareups with profanity, and tears in response to relatively slight frustrations.

- (2) Explosion of aggressive behavior - Sporadic and unpredictable explosions of aggressive behavior (violence) may occur with little or no provocation. Example: a soldier may try to strangle another soldier. The provocation may be a noise, such as the closing of a window, an accidental bumping or normal verbal interaction.
- k. Short Attention Span - Persons under stress may have a short attention span. They find it difficult to concentrate. Short attention span can cause a soldier to have difficulty in following orders. The soldier may easily misperceive and fail to comprehend what others are saying. The person may also have difficulty following directions, aiding others, or performing unfamiliar tasks.
- l. Depression (Numbing of Normal Responsiveness) - Persons may respond to stress with protective defensive reactions against painful perceptions. Emotional dulling, or numbing of normal responsiveness, is a result. (See definition of "Depression" in step one). The reactions are easily observed changes from the individual's usual self.
 - (1) Low energy level - The observer may note decreased effectiveness on the job, decreased ability to think clearly, sleeping too much or difficulty in falling asleep, chronic tiredness. Such qualities as pride, shame, hope, grief, gratitude may no longer matter to the person.
 - (2) Social withdrawal - A soldier may be less talkative than usual or show limited response to jokes. He may be unable to enjoy relaxation and companionship, even when the tactical situation permits. Tearfulness or crying may be noted.
 - (3) Change in outward appearance - In a depressed mood, the observer may note very little body movement and an almost blank, expressionless (mask-like) face.
- m. Substance Abuse - Some soldiers may use substances such as alcohol, or other drugs as a means of escaping combat stress. The use of substances in a combat area may make some soldiers less capable of functioning on the job. They may be less able to adapt to the tremendous demands placed on them in combat.
- n. Disruptive Reactions - Soldiers with disruptive, combat stress reactions (more severe) are those who:
 - (1) cannot function on the job
 - (2) compromise the safety of other soldiers
 - (3) compromise their own safety
- o. Panic Running - The term "panic run" refers to a person who rushes about without any self-control. In combat, a soldier may easily compromise his safety and be killed.
 - (1) If panic is not dealt with early, it can spread to others.

(2) A person in panic is virtually helpless and needs to be protected from injury to himself. More than one person may be needed to provide control. It is important to avoid threatening actions, such as striking a person or dousing a person with water.

C. Provide initial treatment, as time and tactical situation permits.

1. Principles of treatment

- a. Brevity: Treatment should be brief
- b. Immediacy: Treatment begin ASAP
- c. Centrality: Decisions to evac are centralized at each level to prevent over-evac
- d. Expectancy: Expect soldier to return to duty
- e. Proximity: Treat as far forward as possible (within sight and sound of shot and shell)
- f. Simplicity: Keep Treatment simple

NOTE: Point out how first letter of principles above spells BICEPS for easy memory.

2. Treatment of CSR

- a. Rest
 - (1) 4 hours minimum if possible
 - (2) Safe place
- b. Food
- c. Reassurance
 - (1) It's only temporary
 - (2) Not a weakness but exhausted
 - (3) You will be able to return to duty

NOTE: Many soldiers are anxious to return to units ASAP as they feel terrible guilt in letting buddies down, etc. Esprit much higher in combat.

- d. Ventilation
- e. Group support
 - (1) Assign men from same units together, group discussion, sleeping, eating, etc.
 - (2) Temporary support system in place of family

- f. Medications only if necessary
 - (1) Sedation - May be required rarely
 - (2) Stay away from patient image - no pajamas, limited helping duties, etc.
- g. 70% or so will return to duty within 24 - 48 hours
- h. Additional 20% return to duty within 96 hours
- i. Evacuate the more serious (less than 10%)

D. Evacuation Chain for Psychiatric Patients

NOTE: Show slide of "Levels of Health Service Support" (Annex A) in between each of the descriptions below to illustrate the relationship of the whole chain

- 1. Aid person (aidman)

NOTE: 91B Role Changing markedly - 5 hrs Training Planned

- a. Detection of problem
- b. Training in company if possible
- c. Hold CSR patients at company level for 1-4 hours if tactical situation permits
- d. Transport patient to aid station safely if needed

2. Aid Station

NOTE: There are approximately 15 aid stations per division of 20,000 troops

- a. Sorting and disposition
- b. Most forward level of intervention
- c. Physician assistant in charge (may be a physician in charge)
- d. May see 8-9 CSR patients per day
- e. Could stay 4-6 hours

3. Brigade Clearning Station

NOTE: There are usually 3 per division plus the Brigade Clearing Company

- a. No cots
- b. Play down patient role
- c. Could stay up to 48 hours

- d. 70% return to duty CSR's
- e. May have 91G personnel

4. Division Clearing Facility

- a. Division psychiatrist or other mental health worker (psychologist, social worker or possibly nurses)
- b. May be a separate holding area for psychiatric patients
- c. 91G personnel from division
- d. Remaining CSR's turned around here (around 20% of Psyc Prs)
- e. 96 hr capability probable
- f. Serious mental disorders - evacuate (probable 10%)

5. Evacuation Hospitals

- a. 400 bed, two per division (15,000)
- b. May have psychiatric ward
- c. One (1) psychiatric nurse, two (2) 91Fs assigned
- d. Severe psychiatric cases common
- e. May have drug and alcohol cases
- f. Holding policy varies - typically 14-21 days (Keep census down - if patient needs evac - do it quickly)
- g. Located in Corps Support area (Receives support area patients plus evacs from the front)

NOTE: Corp Support Area Dispensaries

- (1) Three sizes of dispensaries (based on number of troops)
- (2) Will have mental health workers attached (what used to be an OM team will be spread out over dispensaries in Corp Support Area)
- (3) Will send patients to evac hospital

NOTE: There will be no Psyc capability at MASH or CSH hospitals

6. General Hospital

- a. 1,000 bed, fixed facility
- b. Located in COMMZ area

NOTE: The COMMZ or Communications Zone, is the rear area of a theater of operations in a battlefield plan. In this day and age it is frequently located far to the rear and usually at a large distance. An example might be that in Vietnam the General Hospitals were located in Japan.

- c. Has psychiatric service
- d. Has psychiatric ward
- e. Five (5) psychiatric nurses, seven (7) 91Fs, one(1) 91B
- f. May be enlarged to meet demand
- g. Prognosis - poor if evacuated this far

NOTE: MACRIT now being planned for psychiatric treatment services throughout system these are only anticipated numbers of personnel and may be adjusted up or down as plans progress.

E. Role of Psychiatric Specialist

- 1. Location
 - a. Not usually assigned forward of EVAC hospital
 - b. May be on OM team and attached to another unit
- 2. Responsibilities
 - a. More responsibilities due to numbers
 - b. May be 91B part of full time
 - c. More medical/surgical cases on ward
 - d. Less nurse/psychiatrist supervision
- 3. Attitudes
 - a. Must support treatment goals
 - b. Kind, compassionate, yet firm
 - c. Less emphasis on illness and more on ability to recover
 - d. An attitude of expectancy must be maintained

F. Questions From Students

III. Summary

A. Review of Main Points

1. Combat stress reaction terms
2. Common reactions to combat stress
3. Initial treatment
4. Medical evacuation or return to duty

B. Closing Statement: The emotionally disturbed soldier is a problem in terms of his own individual health and the success of the mission in which he is involved. It will be your responsibility to recognize and manage the soldier displaying mental health problems. The success of your mission as a medic and soldier will depend upon how well you do this job. Moreover, the success of your unit's mission may depend on how well you perform as the primary mental health care provider.

NOT USED

MANAGE A MASS COMBAT STRESS SYNDROME SITUATION

REF: Coleman, James C., Abnormal Psychology and Modern Life, Chap 6

I. INTRODUCTION

A. OPENING STATEMENT: People exposed to plane crashes, automobile accidents, explosions, fires or other terrifying experiences often display shock reactions. This hour we will discuss the reactions of the populace to terrifying experiences.

B. Objective

1. Given a list of symptoms, identify the symptoms of reactions to catastrophes.
2. Given a list of choices, identify the similarities between combat reactions and reactions to catastrophes.
3. Describe the differences between the treatment for combat reactions and reactions to catastrophes.

II. EXPLANATION

A. Symptoms

1. Depends on nature and severity of terrifying experience, the degree of surprise, and the personality make-up of the individual.
2. Initial "disaster syndrome"
 - a. Shock stage
 - (1) victim is stunned, dazed, and apathetic
 - (2) wanders aimlessly, unaware of extent of his injuries
 - (3) unable to make more than minimal efforts at aiding himself and others
 - (4) extreme cases - individual may be stuporous, disoriented, and amnesiac for the traumatic event

b. Suggestible stage

- (1) passive, suggestible, willing to take directions
- (2) victim expresses extreme concern over welfare of others
- (3) attempts to be of assistance - but behavior is highly inefficient even in performing routine tasks

c. Recovery stage

- (1) individual tense and apprehensive
- (2) shows generalized anxiety
- (3) gradually regains his psychological equilibrium
- (4) has need to tell of catastrophic event repetitively
- (5) in show cases clinical picture may be complicated by intense feelings of grief and depression

B. Similarities

1. Post-traumatic "disaster syndrome"
 - a. may endure for weeks, months, or even years - find same situation in combat cases
 - b. anxiety - ranging from mild apprehension to episodes of acute anxiety
 - c. chronic tension and irritability, often accompanied by fatigability, insomnia, inability to tolerate noise and the complaint "I just can't seem to relax"
 - d. repetitive nightmares reproducing the traumatic incident directly or symbolically
 - e. c/o impaired concentration and memory
 - f. feelings of depression
 - g. in some cases, social withdrawal and avoidance of experiences that might increase excitation as seen by avoid of interpersonal involvement, loss of sexual interest and an attitude of "peace and quiet at any price"
 - h. May be complicated by physical mutilation that necessitates changes in one's way of life
2. Causes behind "shock" reactions seem to be similar to those in reactions to combat
 - a. Psychological make-up of the individual - personality characteristics
 - b. Strangeness and unpredictability of the situation
 - c. length of the disaster situation

C. Treatment for reactions

1. Shock reactions

- a. mild reassuring therapy
- b. proper rest - induced by sedatives if necessary
- c. repetitive talking about the situation

2. Combat exhaustion - immediacy (early detect), proximity (close to FEBA) and expectancy (to go back to battle).

D. Questions from Students

III. SUMMARY

A. Review of Main Points

1. Symptoms of reactions to catastrophes
2. Similarities between combat reactions and catastrophes
3. Treatment for reaction

B. CLOSING STATEMENT: It may be pointed out that many other crisis in addition to terrifying experiences may produce transient personality reactions. There is little information available concerning traumatic experiences but more information should be available soon.

NOT USED

LIST APPROPRIATE EVACUATION METHODS
FOR MENTALLY DISTURBED CASUALTIES

PLACE: Classroom

REFERENCES:

AR 40-535

AF Pamphlet 164-2, chap 10, sec I, pp 10-18

AF Pamphlet 164-5

FM 8 91F1/2 pp 2-22 to 2-30

FORSCOM Message, R221545Z, Aug 78, Subj: Air Evacuation of Psychiatric Patients

STUDY ASSIGNMENT: None

STUDENT UNIFORM AND EQUIPMENT: N/A

TOOLS, EQUIPMENT, AND MATERIALS: N/A

PERSONNEL: One instructor, Psychiatric Specialist

INSTRUCTIONAL AIDS: Alides and slide projector; PA system w/ lapel mike, Instructor will furnish one litter, three blankets, two sheets, one pillow, one pillow case, one air mattress and two litter straps.

TROOP REQUIREMENTS: N/A

TYPE OF INSTRUCTION: Lecture (1 hour), Demonstration (1 hour)

LIST APPROPRIATE EVACUATION METHODS
FOR MENTALLY DISTURBED CASUALTIES

I. INTRODUCTION

A. Opening Statement: What is aeromedical evacuation? As psychiatric specialists, what is our role in the aeromedical evacuation system? It is the policy of the Department of Defense that in both peace and war the movement of patients of the armed forces will be accomplished by airlift -- thus Aeromedical Evacuation, the movement of patients under medical supervision to and between medical treatment facilities by air transportation. As psychiatric specialists we will be involved in the classification and preparation of our patients for air travel. Our understanding of the classification and how the psychiatric patient is prepared for travel will have a direct bearing on his/her safety and the safety of everyone concerned.

B. Objectives

1. Given a list of alternatives, select the purpose and functions of aeromedical evacuation.
2. Given a list of the three types of psychiatric classification, select the correct patient description for each classification.
3. Given a list, select the correct preparation of a psychiatric patient for each of the three types of psychiatric classification.
4. Given a list of alternatives, identify the two (2) criteria necessary for helicopter evacuation of psychiatric patients.
5. Given a list, select the correct method of sending a psychiatric patient's valuables and baggage to the destination hospital for each psychiatric classification.
6. Given a list of alternatives, select the appropriate equipment required to prepare an air evac litter for a psychiatric patient.

C. Class Procedure and Lesson Tie-in

This class will be one hour of lecture and one hour of demonstration. The class ties in with the hours on Admission and Discharge of the Psychiatric Patient.

II. EXPLANATION

NOTE: Use slides to identify main and subtopics.

A. Purpose/Functions

1. Purpose
 - a. Move patients rapidly

- b. Move patients safely
- 2. Functions
 - a. Control of patient movement by air transport
 - b. Provides attendants and equipment
 - c. Provides facilities
 - d. Communication

B. Classification

NOTE: Mention to students that the following classifications pertain to fixed wing aircraft.

QUESTION: Why are patients who are being evacuated classified?

ANSWER: For the safety of the patient and the safety of all personnel concerned.

- 1. Class 1A - Patients posing severe management or control problems
- 2. Class 1B - Patients posing possible management or control problems
- 3. Class 1C - Patients who are cooperative and who have proved reliable under observation

C. Preparation of Patients

1. Physical

- a. Class 1A
 - (1) Hospital pajamas
 - (2) Medication
 - (3) Mechanical restraints
 - (4) Litter
 - (5) Hygiene
 - (6) Comfort articles

NOTE: In placing the 1A patient in restraints we are restricting his/her movements, so there are a few extra physical steps to follow.

- (7) Comfort
- (8) Freedom within safe limits

NOTE: The patient is not to be restrained to the litter

- b. Class 1B

- (1) Hospital pajamas
- (2) Medication
- (3) Litter
- (4) Restraints available
- (5) Hygiene
- (6) Comfort articles

c. Class 1C

- (1) Class "A" uniform
- (2) Ambulatory
- (3) Appearance
- (4) Comfort articles

2. Psychological

- a. Explanation of procedure
- b. Support change in status

3. Administrative

- a. Medical records/forms
 - (1) Evacuation tag (DD 602)
 - (2) Patient's wristband
 - (3) Baggage tag (DD 600)
- b. Valuables

QUESTION: Are patients allowed to carry their valuables on Air-Evac?

ANSWER: 1A and 1B are not; 1C is allowed to carry valuables.

- (1) Class 1A and 1B - Mailed to destination hospital by registered mail.
- (2) Class 1C
 - (a) May retain possessions
 - (b) Encourage mailing

4. Helicopter evacuation

- a. Senior medical officer must certify

- (1) Air transportation is medically essential
- (2) Patient must be sedated and restrained
- b. Air crew accepts patient

NOTE: FORSCOM Message: August 1978, Air Evacuation of psychiatric patients by helicopter. Air evacuation of psychiatric patients is not as critical an adjunct to therapy as it is for the physically ill or injured patient and they may react unpredictably to the air travel especially under adverse operational conditions. Therefore, Army ambulances should not be routinely used to transport psychiatric patients merely as an expedient. Before a diagnosed psychiatric patient may be accepted for air transportation by an air ambulance crew, a senior medical officer must certify that: One, air transportation is medically essential, and two, that the patient is appropriately sedated and restrained to prevent him/her from becoming a hazard to the aircraft and crew.

D. Care of the R.O.N. Patient (Remain Over Night)

NOTE: Military treatment facilities which are in the aeromedical evacuation system provide, when necessary, overnight accommodations for patients being evacuated. During their stay on your wards, their status is that of R.O.N. (patients who will Remain Over Night).

1. Identify patients
2. Identify potential problems
3. DD Form 602
 - a. Nursing notes
 - b. Doctor's orders
4. Insure all records available
5. Physician contact
6. Integrate into ward activities
7. Prepare for departure

III. DEMONSTRATION

A. Preparation of Air Evac Litter

1. Equipment
 - a. One litter
 - b. Three blankets
 - c. Two sheets
 - d. One pillow
 - e. One pillowcase

- f. One air mattress
- g. Two litter straps

2. Steps in procedure

- a. Place air mattress on open litter.
- b. The first blanket is placed lengthwise on the litter with one edge parallel to and even with the litter poles. It is then folded over the litter, the fold being even with the opposite litter pole. The remaining one-third of the blanket is allowed to hang over the side of the litter.
- c. The second blanket is placed over the first one and folded in the same manner, except that the procedure is started with the opposite litter pole.
- d. The sheets are placed on the litter in the same way as the blankets.
- e. If the patient is not placed on the litter immediately after it is prepared, the parts of the sheet and blankets extending over the sides of the litter are fanfolded.
- f. A pillow is placed on the litter for the patient's head.
- g. When the patient is placed on the litter, the sheets are folded over him, and he is covered with a third blanket folded in half lengthwise. The flaps of the first two blankets are then put over the third blanket so that the litter is dressed with four thicknesses of blanket under and over the patient.

B. Questions from Students

IV. SUMMARY

A. Review of Main Points

1. Purpose/Functions
2. Classifications
3. Preparation of patients
4. Care of the R.O.N. patient
5. Preparation of air evac litter

B. Closing Statement: Your attitude toward the proper preparation and initial care you give psychiatric patients who are being air evacuated will have a direct bearing not only on the patient's safety, but the patient's attitude toward further psychiatric care.

NOT USED

COPING WITH DEATH AND DYING

PLACE:

REFERENCE:

TM 8-230 Kubler, Ross, E. On Death and Dying, New York: McMillan Co., 1970.

STUDY ASSIGNMENT:

STUDENT UNIFORM AND EQUIPMENT:

TOOLS, EQUIPMENT, AND MATERIALS:

PERSONNEL:

INSTRUCTIONAL AIDS:

TROOP REQUIREMENTS:

TRANSPORTATION REQUIREMENTS:

TYPE OF INSTRUCTION:

COPING WITH DEATH AND DYING

I. INTRODUCTION

A. Opening Statement: "The long habit of living ill desposeth me for dying." The words are those of Sir Thomas Brown. We learn about death early in our society but in the process we accumulate 'spooky fears'. We need not fear death. We can not know life without death. Patients die in hospitals. Medical personnel can not deny death. In order to give care to the dying patients, you must understand your own feelings as well as those of the patients.

B. Objective

-- Identify the general concept of death including the emotional stages through which the patient and his family resolve their feelings.

II. EXPLANATION

NOTE: Distribute M-64-340-047-1 and let students fill out questionnaire.

A. Attitude about death

1. misinformation
2. refusal to talk
3. fear
4. guilt
5. attitude of others toward patient

B. Stages of dying

NOTE: Dr. Kervler-Ross interviewed dying patients and family and developed information about dying patients.

1. Denial
 - a. Refusal to accept diagnosis
 - b. Doctor made a mistake
 - c. Groping for reassurance
2. Anger
 - a. Why me?
 - b. Anger disposed in all directions
 - c. Will find fault with everything

3. Bargaining
 - a. Attempt to postpone
 - b. Seeks reward "for good behavior"
 - c. Self imposed deadline to give up bad habits
 - d. Promise not to ask for anything else
4. Depression
 - a. Realizes truth and impending loss of life
 - b. Feels guilty
 - c. Two stages
 - (1) Reactive views past losses
 - (2) Preperatory impending loss
5. Acceptance
 - a. Devoid of feeling.
 - b. Family needs more support and understanding
 - c. Non verbal communication
 - d. Less interested in current events

NOTE: Acceptance is difficult stage for family. They often view this as rejection.

QUESTION: In which stages will you observe the patient calm, not interested in current events.

ANSWER: Acceptance is the stage where patient is devoid of feeling

NOTE: Family will also pass through the various stages.

C. Questions from Students

III. SUMMARY

- A. Review of Main Points
 1. Attitude on death
 2. Stages of death and dying
- B. Closing Statement: Dr Kubler-Ross states that the ease by which a patient passes through these stages is often dependent on attitudes of those about him. It is necessary that you minimize your own defensive attitudes toward death and deal with death in order to facilitate the passage of the dying patient through these stages.

END

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